STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	R-C 03/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARBROOK RESIDENTIAL CENTER	1267 PINNACLE CHURCH ROAD NEBO, NC 28761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a Follow Up Survey and complaint investigations on March 7-11, 2016 and March 15-16, 2016.	{D 000}		
{D 072}	10A NCAC 13F .0305(m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level. This Rule is not met as evidenced by: Based on observations the facility failed to assure the exterior grounds were kept in a clean and orderly condition as evidenced by trash thrown over the fence at the 400 Hall smoking area and around the building, and trash and debris around an outside storage building. The findings are: A. Observations and interviews at various times of the inside and outside of the facility on March 7-11, 2016 and March 15-16, 2016 revealed: Observation on 03/07/16 at 10:00 am revealed the building was a straight line block construction approximately 150 feet long with a center hallway and rooms on both sides of the hallway. Continued observation on 03/07/16 between 10:00 am and 11:00 am revealed:	{D 072}		

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{D 072}	Continued From page 1 -The left side of the facility had an additional 8 foot tall chain-link fence running from approximately half way of the building to the left end of the building. The fence was approximately 40 feet from the building; a rolling/sliding gate that was lockable and had a separate 4 foot access gate connected the fence to the building. -The 8 foot fence on the left tied into a 4 foot chain-link fence that extended across the left end of the building, approximately 6 feet behind the left end covered smoking area, and ran along the back of the facility. -There was an opening in the fence, behind the dining room with outside smoking area, which provided access to the facility septic tanks and leach field/drainage system area. -Outside the 4 foot chain-link fence was a wooded area that sloped steeply away from the building. -The fence along the back of the building was approximately 25 to 30 feet from the building. -The 4 foot chain-link fence started again and joined an 8 foot high, barbed wire topped, chain-link fence at the right end of the building (looking from the road), that wrapped around the right end of the facility forming an approximately 20 feet x 30 feet paved area with the facility dumpster and a portable basketball goal located inside the fence. -Residents had open access to all the areas inside the chain-link fences. Observation on 03/07/16 at 9:35 am of the front exterior of building revealed: -There were four raked up piles of pine straw approximately 3 feet in diameter along the front side of the facility between the front smoking area outside the 300-400 hall and the left end of the building.	{D 072}		

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{D 072}	Continued From page 2 Observation during the tour on 03/07/16 at approximately 9:35 am revealed a resident was sweeping the concrete of the 400 Hall outside smoking area. Observation at various times on 03/07/16 to 03/11/16 revealed a resident (same one each time) sweeping the paved area in front of the facility and raking debris into piles in the grassy area between the management trailer and the front of the facility. Observation on 03/07/16 at 10:17 am of the rear exterior of the facility revealed: -A wooden storage shed located behind the kitchen area and approximately 4 feet inside the 4 foot chain-link fence revealed. -Between the building and the chain-link fence, there was a weathered wooden pallet with missing slats. -On the pallet was a gas powered push mower missing rear wheels, missing motor cover, missing handle, and partially covered with leaves. -Next to the pallet were a stack of automobile tires (4), stacked and loose cinder blocks, and a cracked commode tank top (buried in leaves). -Around the outside of the storage building was one upside down toilet tank, 3 additional toilet tank lids (broken or whole), an open 5 gallon plastic bucket labeled "rubber coat" that was partially filled with rain water, a piece of thick rubber or plastic sheeting, and 4 broken chairs. -The shed area was inside the chain-link fence and fully accessible by residents. Continued observation of the area, just outside the 4 foot chain-link fence, behind the storage building and towards the left, revealed an area with 8 empty yellow milk containers, 1 big plastic jug, 3 fresh orange peelings, 5 empty soda cans,	{D 072}		

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{D 072}	Continued From page 3 a paper fast food bag with trash inside, a Styrofoam take-out tray with attached lid, and 2 empty clear plastic cups. Observation on 03/07/16 around 10:30 am and 03/10/16 at 11:25 am of the area just outside the 4 foot chin-link fence behind the facility and further toward the left end revealed various items over the fence and on the steep sloop as follows: -Toward the left end of the building were 7 beer cans, a plastic food jug, and 29 soda cans. -At the left end of the building, behind the covered smoking area, were 13 soda cans, a plastic grocery bag with a cardboard beer carton visible through the plastic, a discarded window blind, three 3 pound coffee containers, and 2 one gallon plastic water jugs. Observation on 03/07/16 at 11:10 am of the fenced dumpster/basketball court area revealed: -A wooden pallet was propped against the inside of fence toward the right side. -Outside the fence at the far right were 2 broken chairs, along with the remains of a broken window. Observations made on 03/10/16 of the 400 Hall outside smoking area at 9:23 am and 11:15 am revealed there were more than 100 cigarette butts and debris over the concrete surface of the area. Observation on 03/15/16 at 3:45 pm of the exterior of the facility revealed: -The smoking area at the left end of facility still had the trash over the fence. -The area just outside the 4 foot chin-link fence behind the facility and further toward the left end still had the same trash and debris over the fence.	{D 072}		

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{D 072}	Continued From page 4 -The area just outside the 4 foot chain-link fence, behind the storage building and towards the left, still had the same debris. -The fenced dumpster/basketball court area still had the overturned chairs and broken window over the fence. Continued observation on 03/15/16 at 3:48 pm revealed: -The smoking area at the left end of facility had 2 empty cigarette packages, a candy wrapper, 2 soda cans, 3 clear plastic cups, and numerous cigarette butts. -In the 6 foot area between the smoking area and the 4 foot chain-link fence was observed 7 snack wrappers. -The smoking area outside the 300-400 Hall (in front of the facility) had trash as follows: 1 empty Vienna sausage can, 2 clear plastic cups, and 1 soda can on the concrete area. -The 4 piles of raked pine needle were still along the front of the building. Observations on 3/16/16 at 10:38 am of the 300 Hall smoking porch and surrounding area revealed the trash observations made on 3/15/16 at 3:48 pm were still present with numerous cigarette butts covering the concrete surface. Interview with the AOM on 03/11/16 at 11:00 am revealed: -He was responsible for the upkeep of the grounds and housekeeping. -He stated the grounds should be cleaned up weekly by housekeeping staff. -He said the land between the two fences was private property. -He did not clean that area; he had not contacted the owner and did not know who owned the land.	{D 072}		

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{D 072}	Continued From page 5 Additional interview on 03/15/16 at 3:30 pm with the Assistant Operation Manager (AOM) revealed: -He was responsible for the overall maintenance and upkeep of the facility. -He assigned duties to the Maintenance Supervisor (MS) at least once a day. -He and/or the Operation Manager (OM) conducted a daily walk through the building for cleaning/maintenance assignments. -Residents, caregivers, and housekeepers could submit list of items needing repair. -The AOM forwarded the MS the list of tasks to be done. -The facility has a new maintenance staff person to assist the MS. -The Housekeeping Supervisor would be responsible for overseeing collecting trash, mopping the facility, and room cleaning.	{D 072}		
{D 074}	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to make repairs to or maintain in clean condition floors, walls, ceilings, doors, dining room tables and chairs, and light fixtures throughout the facility. The findings are:	{D 074}		

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{D 074}	Continued From page 6 A. Observations and interviews on various days and times throughout the facility revealed: Observation on 03/10/16 at 11:05 am of the dining room area revealed a torn window screen in the right side of one of the 4 windows in the main dining hall. The left lower corner of the screen was torn about 24 inches up and 6 inches across the bottom. Observation on 03/10/16 at 11:10 am of the dining room area revealed 8 pedestal dining tables and 49 plastic chair with metal bottoms in main and second dining rooms in need of cleaning from spills, dust and build-up of food. Observation on 03/10/16 at 11:25 am of room D, occupied by 3 residents, revealed: -The radiator/heater was missing part of the metal covering on the left end exposing the radiator coils and fins. -The radiator/heater line had been cut and an auxiliary line run through the wall, along the outside of the building, to the boiler room. -The hose attached to the floor radiator/heater was leaking hot water onto the floor. (Puddle approximately 2 inches in diameter.) Interview on 03/10/16 at 11:28 am with Maintenance Supervisor revealed: -He was in charge of the maintenance for the building. -The Assistant Operations Manager (AOM) assigned him various repair duties. -The facility had a water leak somewhere under the concrete floor on the 300 hall that caused loss of hot water. -A plumber had bypassed the water flow at room D with a return to the boiler in attempt to isolate the water leak.	{D 074}		

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{D 074}	Continued From page 7 -He knew the baseboard heater cover was not in place. -He believed all of the residents on that side of the hall had been moved on 03/09/16 to other rooms because of the boiler leak and no heat. -Room D was not supposed to have residents until he had completed repairs to the radiator pipe cover, however the AOM moved residents into the room before he could get the room blocked off. Interview on 03/15/16 at 3:30 pm with the Assistant Operation Manager (AOM) revealed: -He was responsible for the overall maintance and upkeep of the building. -He assigned duties to the Maintenance Supervisor (MS) at least once a day. -He and/or the Operation Manager (OM) conducted a daily walk through the building for cleaning/maintenance assignments. -Residents, caregivers, and housekeepers can give list of items needing repair. -The MS received a list of task to be done from the AOM. -The facility has a new maintenance staff person to assist the MS. B. Observations on 03/07/16 from 8:15 am to 11:00 am during the initial tour revealed: -In the common bathroom on the 200 hall there was a brown stain spattered on the commode seat and down the side of the commode. -In room I on the two outside walls there were what appeared to be liquid stains running down the walls near the corner of the room where the outside walls adjoin. The ceiling in this area had brown splotches, similar in appearance of water damage. -In the shared bathroom between rooms E-F the light switch faceplate had two cracks emanating	{D 074}		

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{D 074}	Continued From page 8 from the lower holding screw. There was a dark brown/black stain on the floor in the area around and behind the commode. Interview with the Assistant Operations Manager (AOM) on 03/07/16 at 9:25 am revealed since the last survey they had increased housekeeping and maintenance staffing by one per department. They also focused heavily on maintenance and housekeeping issues, heavy cleaning and now go back room by room on a rotation basis, continuing with deep cleaning areas. Observation on 03/07/16 at 3:20 pm revealed the commode in the common bathroom on 200 hall had been cleaned and the brown spattering was removed. Interview with the AOM on 03/11/16 at 12:25 pm revealed he had learned of the water damage in room I about three weeks ago. The roof was leaking and they recently had it repaired by a local roofing company. Interview with a housekeeper on 03/15/16 at 2:15 pm revealed: -He had been at the facility for about two months. -When he encountered a stained area on the floor he sprays the area with a cleaning product, gave it time to soak in and then would go back and scrub the area. Observation on 03/15/16 at 4:00 pm revealed the light switch faceplate in the shared bathroom between rooms E-F was still cracked and had not been replaced. C. Observations on 03/7/16 at 8:52 am in room H bathroom revealed there was a strong smell of urine with water and rust staining along the	{D 074}		

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{D 074}	Continued From page 9 baseboards in the bathroom. Observation on 03/07/16 at 11:14 am of resident room J revealed: -There was a dark yellow dried substance that ran down wall from the ceiling onto the floor. -There was black colored substance on the floor along the walls and under the heat register. -The sink was dirty with dark colored rings on the countertop, the inside sink bowl was stained brownish yellow and there were three dirty cups. Observations on 03/09/16 at 11:00 am in the Main Dining room revealed: -There was a large 8' x 10' liquid spill in the walk way where some liquid had dried and some was sticky. -The spill remained through lunch and bingo until approximately 3:00 pm when it was cleaned up. Observations on 03/10/16 at 9:00 am in the main dining room revealed there was build up of dirt, liquids and food particles spills contained in a an area approximately 12' x 4' in the main aisle of the room and also before the dining room roll up kitchen access window. (Cleaned up at 10:00 am). Observations on 03/10/16 at 9:05 am in room J revealed there was a box fan with a 1/8" thick coating of dust/dirt on the fan blades edges and fan guard grid. Observations on 03/10/16 at 9:15 am in room D occupied by 3 residents revealed: -The floor was dirty with spills and trash. -A box fan labeled "D" had dust buildup on blades and fan guard grid -The dresser had dirt, spills and food crumbs on top.	{D 074}		

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{D 074}	Continued From page 10 -An open bathroom baseboard heater had no cover and had water pooling on the floor and staining along the wall to back of toilet. -Water was running into the open drain with a diverting plastic tubing going outside through a hole in the concrete brick. -There was a 12" pool of water on the floor of the bathroom where the pipe goes into the drain and water accumulating along the wall with wet paper towels beside the toilet. Interview with the Maintenance Supervisor on 03/10/16 at 11:30 am regarding room D revealed: -He knew the baseboard heater cover was not in place. -He believed all of the residents on that side of the hall had been moved on 3/9/16 to other rooms because of the boiler leak and no heat. -He had planned on painting the stained cover while repairs to the boiler were being made. -He was not aware residents had moved back into the room and were using the bathroom. Observations on 03/10/16 at 3:45 pm in D's bathroom revealed the baseboard heater cover was replaced and roughly repainted leaving the surface rough and uneven; the water pools and paper towels remained on the floor. Observations on 03/10/16 at 9:23 am in 400 Hall odd bathroom revealed: -There was a large puddle of water and the floor was dirty. -A rust stained base board heater cover with heavy buildup of scum. -An accumulation of brown dried scum along edges of the junction wall to flooring extending 1" in most areas. -The shower curtain was torn and missing 2 hooks at the end of the curtain.	{D 074}		

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{D 074}	Continued From page 11 Observations on 03/11/16 at 9:00am in the 400 Hall odd bathroom revealed: -Several piles of paper towels scattered over the floor surface with puddles of water by the sink and shower. -The shower curtain was torn and missing 2 hooks at the end of the curtain. Observation on 03/10/16 at 9:40 am in room B revealed a large liquid spill approximately 4' x 4' in the doorway and beside a resident bed. Interview with a Personal Care Aide on 03/10/16 at 9:40 am revealed: -She thought the liquid was urine because the resident who slept in the bed beside the spill, liked to urinate in the wastebasket. -She had already asked Housekeeping to clean it up about 10 minutes before but was told they would get to it when they could. Observations on 03/10/16 at 3:50 pm in room 401 revealed: -A box fan labeled "M" which had a 1/8" heavy buildup of dirt/dust on the edges of the fan blades and the fan blade grid. -A heavy buildup of dirt/scum 1" along the door/frame extending along the wall to the closet. Observations on 03/11/16 at 9:05 am in the 400 Hall even bathroom revealed the floor was water stained with towels on the floor, puddles of water by the sink and a pile of washcloths by the toilet. Observations on 03/15/16 at 4:00 pm in room G revealed: -A concentrated odor of cigarette smoke. -There were 2 cigarette butts in the toilet and the bathroom window was opened.	{D 074}		

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{D 074}	Continued From page 12 -The bathroom floor was soiled with dried stains, wet puddles and wet toilet paper scraps beside the toilet base. -There was a 1" area of dried soap/wax/dirt buildup all along the wall. - One cigarette butt was in the resident room on the floor before the door. Interview with the Assistant Operations Manager on 03/11/16 at 11:00 am revealed: -He was in charge of Housekeeping and Grounds for the facility. -He used a schedule of deep and regular cleaning with deep cleaning occurring on Mondays usually. -Housekeeping staff was scheduled to sweep/mop all room, check under beds, wipe furniture, supply soap, toilet paper and paper towels, empty trash, and clean bathroom fixtures. -He said the residents can and do refuse to have their rooms cleaned. -Portable box fans are cleaned seasonally or if the resident requested but not on a schedule.	{D 074}		
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by:	{D 079}		

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{D 079}	Continued From page 13 FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, record reviews and interviews, the facility failed to assure it was maintained free of all obstructions and hazards in regards to cleaning up around a storage shed in back of the facility which was fully accessible to resident and posed a trip or fall hazard, repairing an outside light fixture, repairing metal baseboard heater covers in 2 residents rooms (Rooms #D and #J), covering an outside water line (Room #D), repairing a sink fixture (Room #K), improper fitting lock (Room #C), and a hole in the foot of the bed (Room #L). The findings are: A. Observations and interviews on various days and times throughout the facility revealed: Observation on 03/07/16 at 10:27 am of room L, bed by the door revealed: -There was a 12 inch long by 18 inch wide hole in the foot of the bed. Interview on 03/07/16 at 10:28 am with the resident sitting on the bed revealed: -He did not know what happened to the bed because he was out of the facility when the hole happened. Observation on 03/07/16 at 11:14 am of resident room J revealed: -A 6 inch piece of metal was sticking up from the heat register. -The sink was dirty with dark colored rings on the countertop, the sink bowl was brownish yellow	{D 079}		

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{D 079}	Continued From page 14 inside. -Also sitting on the countertop were three dirty cups. -The countertop also had a crack on the front edge of the counter. Observation on 03/07/16 at 11:15 am of room J revealed; -A yellow substance on the wall was dripping from the pipes in the ceiling. -The substance had dried. Observation of the heat register in room B on 03/07/16 at 10:30 am revealed it was dirty and discolored with yellow and brownish stains. The floor underneath the heat register was discolored with black, yellow and brownish unidentified stains. Observation on 03/07/16 at 11:45 am of room K revealed: -The metal stripping around the sink was broken in half in the middle-front of the sink, and sticking up. -The metal was sticking up enough to scrape or possibly cut someone. Interview on 03/07/16 at 11:45 am with the resident in room K revealed: -The sink had been that way since she moved into the room (something in January or February 2016). -She had not gotten cut or scratched herself on the metal sticking up. -She washed and showered in the big common bathroom and did not use the sink that often. Interview on 03/07/16 at 10:16 am with the Assistance Operations Manager revealed: -They had been working on cleaning floors, they	{D 079}		

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{D 079}	Continued From page 15 cleaned the floors in the bathrooms as mentioned on the survey report, but there was no mention of the floors in the residents rooms. -At some point all floors will be done over. B. Observations and interviews on various days and times throughout the facility revealed: Observation on 03/07/16 at 9:30 am, Room C revealed the door lock receiving plate had no screws holding it in place and moved around in the cut out space; the door lock plate would get caught when the door closed causing difficulty opening and closing the door. Interview with a resident who resided in room C on 03/9/16 revealed: -The plate had been missing it's screws for a long time and sometimes the door catches but he just "wiggles" it. -He had asked the Maintenance "guy" to fix it a while back, but he would tell him again. Observation on 03/07/16 at 9:55 am of the exterior of the facility revealed an exterior light fixture that was missing a light bulb which exposed the ceramic bulb socket located outside the exit door to covered smoking area at the 300-400 Hall. Observation on 03/15/16 at 11:00 am revealed the light fixture located outside the exit door to covered smoking area at 300-400 Hall had been replaced. Observation on 03/07/16 at 10:17 am of the rear exterior of the facility revealed: -A wooden storage shed located behind the kitchen area and approximately 4 feet inside the 4 foot chain-link fence revealed.	{D 079}		

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{D 079}	Continued From page 16 -Between the building and the chain-link fence, there was a weathered wooden pallet with missing slats. -On the pallet was a gas powered push mower missing rear wheels, missing motor cover, missing handle, and partially covered with leaves. -Next to the pallet were a stack of automobile tires (4), stacked and loose cinder blocks, and a cracked commode tank top (buried in leaves). -Around the outside of the storage building was one upside down toilet tank, 3 additional toilet tank lids (broken or whole), an open 5 gallon plastic bucket labeled "rubber coat" that was partially filled with rain water, a piece of thick rubber or plastic sheeting, and 4 broken chairs. -The shed area was inside the chain-link fence and fully accessible by residents which posed a trip, stumble or fall hazard. Observation on 03/10/16 at 11:25 am revealed a white 1.5 inch diameter auxiliary line run through the wall of room D, along outside of the building, and ending at the boiler room. Interview on 03/10/16 at 11:28 am with Maintenance Supervisor revealed: -He was in charge of the maintenance for the building. -The Assistant Operations Manager (AOM) assigned him various repair duties. -The facility had a water leak somewhere under the floor on the 300 hall that caused loss of hot water. -A plumbing service had bypassed the water flow at room D with a return to the boiler in attempt to isolate the water leak. -The main water lines from the boiler ran under the tile floor inside the building and fixing any leaks would require chiseling up the floor to access the leak. (Finding the leak would require	{D 079}		

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{D 079}	Continued From page 17 the use of a thermal imager to locate pooled hot water under the concrete floor.) -The outside area was accessible to residents. Interview on 03/15/16 at 3:30 pm with the Assistant Operation Manager (AOM) revealed: -He was responsible for the overall maintance and upkeep of the building. -He assigned duties to the Maintenance Supervisor (MS) at least once a day. -The AOM and/or the Operation Manager (OM) conducted a daily walk through the building for cleaning/maintenance assignments. -Resident, caregivers, and housekeepers can give list of items needing repair. -The MS received a list of tasks to be done from the AOM. -The facility has a new maintenance staff person to assist the MS. -The Housekeeping Supervisor would be responsible for overseeing collecting trash, mopping the facility, and room cleaning.	{D 079}		
{D 087}	10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case;	{D 087}		

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{D 087}	Continued From page 18 (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents' mattresses were clean, in good condition and had bed linens clean and in good repair as evidenced by dirty and ripped mattresses and dirty, stained bed linens on residents' beds. The findings are: A. Observations and interviews on various days and times in the facility revealed: Observations on 03/07/16 at 8:52 am in room H, revealed the bed on the interior wall had a stained bottom sheet and two pillow cases which were gray, dingy, stained and had holes. Observation in the laundry room on 03/7/16 at 9:15 am to 9:30 am revealed: -A Housekeeper was in the room folding linen and placing the linens into the laundry cart. -There were a number of sheets folded in a variety of color from whitish to grayish and there were some holes in several of the sheets. -There were several blue bed spreads with holes and one had a bleached spot. Interview with the Housekeeper on 03/7/16 at 9:15 am revealed: -He was responsible for the laundry and that was his new job.	{D 087}		

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{D 087}	Continued From page 19 -He still swept and cleaned resident rooms when assigned. -He did not throw away or discard torn or dingy linens unless someone told him to. Observations on 03/07/16 at 8:53 am in room I, the visible box spring for the bed under the window was stained and torn. Observation on 03/07/16 at 11:48 am of the mattress in room B revealed: -The mattress had 2½ - 3 inch wide black tape applied in 7 places on the mattress. -The resident who slept in the bed was not in the room, but the roommate confirmed a resident slept in the bed every night. Observation on 3/11/16 at 11:00 am in room B revealed the mattress was still taped and the floor was wet from an unknown liquid. Observation on 3/11/16 at 11:10 am in room G revealed the linens on the bed were tattered, torn and dingy. Observation on 3/15/16 at 11:00 am in room G revealed: -The linens appeared to be the same as those observed on 3/11/16. -The sheets were disarrayed and the bottom sheet dingy, stained and wadded into a ball. -The top sheet and spread were piled up at the foot of bed. - Both pillow cases were stained with multiple rust colored stains. -One of the cases covering the lower pillow case was dirty appearing - dark gray in color. Additional observations made on 03/15/16 at 11:00 am in room G revealed revealed:	{D 087}		

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{D 087}	Continued From page 20 -The box spring mattress on the bed under the window was badly stained on the top and sides. -The bottom sheet on the bed was torn at the corner and side. Interview with a Personal Care Aide on 3/15/16 at 2:20 pm revealed: -The aides are responsible for changing linens on bath days. -She was not working as an aide today, but was not seeing much bathing or bed changing done today. -When she used to do laundry, she would throw out soiled and torn linens, but did not know what was being done lately. -She would let housekeeping know if there were problems with a mattress. B. Observation on 03/11/16 at 1:10 pm of room A revealed: -A strong urine smell was observed inside the room. -One resident currently resided in the room. (During the initial tour on 03/07/16 there were two residents assigned and present in the room.) -The bed located on the outside wall had the top spread pulled over the bed. -The bottom sheet was slightly damp with a strong urine smell. -The mattress was constructed with a vinyl type covering. -The covering had multiple small cracks in the center of the mattress that ran lengthwise for approximately 10 inches which could allow seepage into the mattress components. Interview on 03/11/16 at 1:15 pm with the former resident in room A revealed: -She had moved out of room A today (03/11/16).	{D 087}		

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{D 087}	Continued From page 21 -She had the bed next to the interior wall. -She had been complaining to Operations Manager for several days that she did not like the strong urine smell coming from the opposite side of the room (outside wall). Interview with a Personal Care Aide on 3/11/16 at 1:10 pm revealed: -The resident who slept in the bed on the outside wall (in room A) was frequently incontinent of urine. -There had been 2 residents in room A . -She thought one resident moved out the day before because of the smell of urine in the room. Interview on 03/11/16 at 1:18 pm with the Operations Manager revealed: -The resident in room A was incontinent of urine. -Staff checked the resident every 2 hours for continence. -She was not aware until today (03/11/16) that the resident's mattress was cracked. Observation on 03/11/16 at 2:00 pm revealed the mattress with cracks was removed by staff from room A .	{D 087}		
{D 188}	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide	{D 188}		

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{D 188}	Continued From page 22 duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues.	{D 188}		

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{D 188}	Continued From page 23 Based on record review, observation and interview, the facility failed to assure staffing met minimal requirements according to census for 4 of 13 "second" shifts from February 23, 2016 through March 6, 2016. The findings are: Review of the facility's daily census record for February and March 2016 revealed the facility's in house census between 02/23/16 and 03/06/16 was 56-59 each day. Review of the second shift schedule, time cards and daily census for 02/23/16 through 03/06/16 revealed: -4 of 13 shifts were staffed below the minimum of 28 personal care hours which included 4 hours of Supervision as follows: Tuesday, 02/23/16, there were 6 staff for a total of 26.75 hours. Saturday, 02/27/16, there were 4 staff for a total of 25.50 hours. Monday, 02/29/16, there were 5 staff for a total of 25.25 hours. Wednesday, 03/02/16, there were 4 staff for a total of 26.50 hours. -The remaining 9 of 13 shifts exceeded in the minimum of 28 personal care hours which included 4 hours of supervision, with a range of 5 to 7 staff and with a range of 29.50 to 39.50 hours. Total staff hours for Medication Aides (MA) and Personal Care Aides (PCA) per shift from 02/23/16 to 03/06/16 revealed: 02/23/16, first shift-44.25, second shift-23.75 (RCC at facility 3.00), third shift-24.50. 02/24/16, 58.75, 33.00, 24.25.02/25/16, 42.75,	{D 188}		

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{D 188}	Continued From page 24 37.75, 24.25. 02/26/16, 30.75, 39.75, 16.00. 02/27/16, 37.50, 25.50, 16.00 02/28/16, 37.00, 38.75, 21.25. 02/29/16, 21.25 (RCC at facility 5.75), 23.25 (RCC 2.00), 34.50. 03/01/16, 29.50, 32.00, 16.59. 03/02/16, 31.75, 23.00 (RCC 3.50), 16.00. 03/03/16, 31.75, 34.25, 16.00 03/04/16, 31.25, 35.50, 16.00 03/05/16, 19.50 (RCC 8.00), 41.50, 16.00. 03/06/16, 20.50 (RCC 8.00), 40.50, 15.75. Interview with the Operations Manager (OM) on 03/08/16 at 11:00 am revealed she staffed the facility based on daily census. Interview with the Operations Manager (OM) on 03/10/16 at 2.45 pm revealed: -The Resident Care Coordinator (RCC) initially creates a two-week staffing scheduled. -The RCC sends the schedule to the OM for review and approval. -The Vice President of Operations created a new staffing form that will assist in tracking staffing hours and assuring the facility is staffed to census. -She was responsible to assure staffing in the facility meets the rule area. -They had just completed a two-week pay period and was working with the business office to determine if there were any exceptions to the schedule. -She was not aware of the reason(s) that there were 4 shifts below the minimum personal care hours. -She did not recall any resident incidents that occurred on those days. Review on 03/10/16 of the staffing sheet form	{D 188}		

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{D 188}	Continued From page 25 revealed the following information could be documented; date, required hours, medication aide, floor aide (personal care aide), and supervisor for 1st, 2nd and 3rd shifts. There were entries for two days per page. Observation of 03/07/16 at 11.43 am of a staffing sheet posted in the employee lounge for 03/05/16 and 03/06/16. Interview on 03/15/16 at 11:00 am with the RCC revealed: -She and the OM made the two-week staffing schedule for the Medication Aides (MAs) and personal care aides (PCA). -The new staffing sheet allowed them to identify staffing gaps for each shift. -She or the OM would work on getting any staffing gaps filled. When she or the OM were not available then the MA/supervisor would work on finding staff to fill the gap. -If no staff could be found then she or the OM would cover that shift or time period. -She worked late a lot and would cover the cart when needed. -She was not aware of the reason(s) that there were 4 shifts below the minimum personal care hours. -She did not recall any resident incidents that occurred on those days. Interview with a MA on 03/15/16 at 2:55 pm revealed she had worked three of the days (02/23/16, 02/29/16, 03/02/16) that the shift was below the minimum personal care hours. She could not recall any resident incidents on days or reasons they would have needed more staff than what was in the facility. Interview on 03/07/16 with a PCA revealed they	{D 188}		

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{D 188}	Continued From page 26 were the only PCA on shift. The PCA was responsible to provide personal care services for the residents, such as bathing and dressing assistance. There used to be 2 PCAs but one quit. Being the only PCA on shift happened "very often". The PCA felt the residents were being cared for yet the PCA was tired of being the only staff doing all of the work. Observation on 03/16/16 at 10:30 am revealed 2 PCAs were sitting in the smoking area outside of the 300 hall day room. Observation on 03/16/16 at 4:20 pm revealed three PCAs were seated in the staff lounge. A loud, verbal outburst was heard coming from the hallway. All three PCAs responded down the hallway. Approximately one minute later all three returned to the lounge and sat back down. Interview with three PCAs on 03/16/16 at 4:25 pm revealed: -Two of the PCAs were on duty and one was at the facility training as a MA. -They went down the hallway to find a MA was with a resident who was upset about running out of cigarettes. -All three stated they had enough staff on second shift to do the work. -One PCA remembered being short staffed because another PCA had a medical issue. -One PCA stated she was out of the facility during those days due to a medical issue. -They could not remember any resident issues caused by being short staffed. -They stated the MAs would come out and help them cover the floor, take care of resident needs when not giving medications. Interview with a second MA on 03/16/16 at 5:05	{D 188}		

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{D 188}	Continued From page 27 pm revealed she had worked two of the days (02/27/16, 03/2/16) that the shift was below the minimum personal care hours. She could not recall any resident incidents on those days or any issues caused by being short staffed. The RCC was good to get missing shifts covered and would help cover shifts if no other staff was available to work. She and the other second shift MAs were "good to help on the floor." Review of the local county 9-1-1 communications log revealed there were no calls made from the facility on 02/23/16, 02/27/16, 02/29/16 or 03/02/16 during second shift (3:00 pm to 11:00 pm).	{D 188}		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on interviews, record reviews, and observations, the facility failed to assure staff provided supervision in accordance with 3 of 9 residents' (Resident #2, #22 and #9) assessed needs and current symptoms resulting in Resident #2 leaving the facility property multiple	{D 270}		

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{D 270}	Continued From page 28	{D 270}		

times unsupervised looking for drugs, attempted self-harm multiple times, and walking into traffic; Resident #22 leaving the facility property unsupervised and found by a sheriff deputy on the interstate approximately 4-6 miles from the facility; and Resident #9 performing sexual favors for $2.00 and soda.

The findings are:

A. Review of Resident #2's current FL2 dated 12/16/15 revealed:
-Diagnoses included post-traumatic stress disorder (PTSD), seizures, poly substance abuse.
-Documented disoriented as constantly/ intermittently.
-Documented inappropriate behaviors, wanderer, verbally abusive, injurious to self, injurious to others, and injurious to property.

Review of Resident #2's FL2 handed to surveyor by the Resident Care Coordinator (RCC) on 03/11/16 and dated 02/18/16 revealed:
-Diagnoses included seizures, mood disorder, and post-traumatic stress disorder,
-No documentation of being disoriented or inappropriate behavior.

Review of Resident #2's record revealed:
-She was admitted to the facility on 02/27/15.
-Resident #2 had a guardian.

Review of Resident #2's facility charting notes for December 2015 revealed Resident #2 was served papers for a court date of 01/15/16, and Resident #2 told staff she wanted to marry her boyfriend who was a resident at the at facility.

Review of Resident #2's facility incident reports for the month of December 2015 revealed

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{D 270}	Continued From page 29 documentation for Resident #2 hit her arm on the door, two attempts self-harm by cutting wrists and wrapping an electrical cord around her neck, screaming and cussing staff, IVC evaluation, and left the facility walking up the driveway. Review of Resident #2's record revealed a hospital discharge summary dated 12/16/15 reason for hospitalization was suicidal ideations, discharged diagnoses included schizoaffective disorder, post-traumatic stress disorder, and cannabis and cocaine abuse, Resident #2 was discharged back to the facility. Interview on 03/16/16 at 3:35 pm with a Medication Aide (MA) revealed: -She administered first aid to Resident #2 after Resident #2 had cut her wrist at least two times. -One time involved both wrists with multiple skin lacerations with a small amount of blood, which she cleaned with wound cleaner and applied bandages. -The second time involved only one wrist which she cleaned with wound cleaner and bandaged. -She had searched Resident #2's room and removed all items that would cause self-harm both times. Review of the facility charting notes for January 2016 for Resident #2 revealed: -On 01/01/16 at 5:13 pm, Resident #2 had broken her birth control implant. The Guardian requested intramuscularly birth control injection for Resident #2. -On 01/04/16 at 11:54 am, Resident #2 had an appointment with the probation officer and tested positive for methamphetamines. Resident stated she got the drugs from the house up the road. Facility management will investigate and inform the local law enforcement.	{D 270}		

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{D 270}	Continued From page 30 -On 01/10/16 at 10:35 pm, Resident #2 requested a facility staff phone number and social media site. The Supervisor -In-Charge (SIC) notified management. -On 01/13/16 at 9:27 pm, Resident refused all 8:00 pm medications. -On 01/20/16 9:06 pm Resident #2 refused medications several times consecutive, physician, guardian and mental health were notified. -On 01/21/16 at 10:24 pm, Resident #2 had increased behavior due to getting into a verbal altercation with boyfriend. Staff attempted to redirect Resident #2 several times; the sheriff's department was called to the facility. The sheriff deputy informed Resident #2 to stay away from boyfriend. Resident #2 slammed the door in the sheriff deputy's face; the deputy talked again to Resident #2. The sheriff deputy left the facility. Resident #2 walked away from the facility property again after the sheriff deputy left the facility. Resident #2 told staff she was going to get drugs at the drug house. Staff tried to redirect and get Resident #2 to come back to the facility, but Resident #2 refused. Facility called guardian, mental health, and the probation officer. Resident #2 came back to the facility a short time later, and refused her Finger Stick Blood Sugar (FSBS) and insulin. -On 01/24/16 at 5:01 am, Resident #2 in a verbal altercation with boyfriend. Staff redirected both Resident #2 and boyfriend. 15 minute check are in place and has been continued. Review of Resident #2's facility incident reports for the month of January 2016 revealed: -On 01/02/16 at 8:50 am, Resident #2 is arguing with her boyfriend. Staff redirects and Resident #2 starts yelling and threatening staff. Mobile crisis called, on call guardian contacted. Notified sheriff department Resident #2 walked away from	{D 270}		

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{D 270}	Continued From page 31	{D 270}		

facility. Crisis contacted again for continued behaviors.
-On 01/06/15 at 8:15 am, Resident #2 punched the wall. Mobile x-ray called.
-On 01/07/16 1:00 pm, Resident #2 was arguing with boyfriend and walked off the facility property. Crisis control and guardian called, Resident #2 returned to the facility with staff at 1:25 pm.
-On 01/21/16 at 4:30 pm, Resident #2 arguing with boyfriend and walked away from facility. Mobile crisis and guardian contacted. Resident #2 returned around 5:00 pm.

Review of the crisis treatment team meeting minutes for the month of January 2016 revealed:
-Resident #2 had been IVC'd, placed on probation, and failed a Urine Drug Screen.
-Resident #2 felt safe at the facility now, and her aggression has decreased, but she is still verbally aggressive at times.
-Guardian was concerned "Is the facility the right place for Resident #2."
-Guardian was concerned with Resident #2's medication refusals.
-The ACT team leader planned to meet with the facility Operation's Manager to discuss ways the staff can react to Resident #2's crisis situations.

Review of the facility charting notes for February 2016 for Resident #2 revealed:
-On 02/04/16 at 11:11 pm, Resident #2 with extreme agitation this afternoon. Altercation with boyfriend staff intervened. Resident #2 attempted to harm self on several occasions. Mobile crisis contacted (contacted twice due to attempted cutting wrist and attempted to drown herself in the bathtub). Medication administered and the crisis plan were not effective. Mobile crisis petitioned for Involuntary Commitment (IVC).
-On 02/10/16 at 4:34 pm, the Operations

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{D 270}	Continued From page 32 Manager (OM) met with Resident #2 and she does not want to move from the facility because she wants to marry her boyfriend. The OM informed the guardian on 02/11/16. -On 02/19/16 at 10:38 pm, Resident #2 with increase agitation and anxiety. Facility staff contacted mobile crisis. Resident #2 stating if she could not be with her boyfriend whom she loved she would end her life. Sheriff deputy arrived and transported to Emergency Room (ER) for evaluation. Review of Resident #2's facility incident reports for the month of February 2016 revealed: -On 02/04/16 at 4:30 pm, Resident #2 attempted to go into bathroom and drown herself in bathtub full of water. Staff intervened at that time. Mobile crisis contacted. Resident #2 was upset over phone. 15 minute checks advised, Crisis plan in play for coping skills. On call guardian contacted. -On 02/04/16 at 5:05 pm, Resident #2 with self-injury to left wrist. Mobile crisis contacted, on call guardian contacted. Searched Resident #2's room, safety precautions taking object that could harm self and others. 15 minutes checks continued. First aid administered cleaned and bandaged wrist. -On 02/17/16 at 4:30 pm, Resident #2 said another resident jerked her arm. Crisis contacted. Resident #2 denied hitting anyone. -On 02/19/16 at 2:30 pm, Resident #2 was arguing with boyfriend. Resident #2 became agitated and cursing staff. Resident #2 went into her room got a pair of scissors and threatened to harm herself. Crisis control was present. Resident #2 refused to give up scissors threatening to kill herself. Sheriff's department contacted, on call guardian called. Documented mobile crisis couldn't petition for IVC. -On 02/21/16 at 5:30 pm, Resident #2 was in her	{D 270}		

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{D 270}	Continued From page 33 room, staff was told by another resident that Resident #2 was having a seizure. Sent to ER for evaluation. On call Guardian contacted. Review of Resident #2's hospital discharge summary dated 02/20/16 revealed: -Resident #2 was admitted to the hospital under IVC for attempt to injure self. -Resident #2 had aggressive behaviors, throwing objects, and attempted to cut self with scissors with verbal expression of "more ways to kill herself." -Evaluation stated Resident #2 had returned to the ER under similar IVC petition once or twice monthly. -The local mental health provider for Resident #2 are working with another mental health provider closer to her family on emergency placement elsewhere, "To get her someplace with better supervision." -Documentation Resident #2 did not need to be placed where she could come and go easily. -The facility will take her back while they are working on new placement for Resident #2. -Documentation the local mental health provider had daily crisis calls for the facility that week. -Documentation the local mental health provider does not know if Resident #2 needs medication adjustment, respite, or perhaps relocation, "Advocates for placing Resident #2 in inpatient treatment to, Teach her a lesson so maybe she won't keep doing this." -Documentation Resident #2 was told her mental health care team was arranging to relocate her to a more supervised facility. -Resident #2 was returned back the facility on 02/20/16. Review of the facility charting notes for March 2016 for Resident #2 revealed:	{D 270}		

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{D 270}	Continued From page 34 -On 03/06/16 at 10:50 pm, Resident #2 walked away from the facility property around 6:40 pm. Resident with increase behaviors through the weekend. Resident #2 walked into the woods and refused to return to the facility. Mobile crisis was contacted. Resident returned to facility on her own around 7:00 pm. Resident #2 refused to go the ER for evaluation for voluntary commitment. Resident #2 was currently on 15 minute checks. Resident #2 was missing from the building around 7:30 pm. Resident #2 was located by staff at church near the facility, Resident #2 said she was going to meet someone and get drugs. Guardian was called and the SIC documented the guardian said if Resident #2 does not return by 8:30 pm to contact the sheriff department and file a missing person report. Resident #2 returned to the facility around 8:15 pm on her own. Resident #2 refused all 5:30 pm medications as well as 8:00 pm medications. Resident #2 had been in bed since returning to the facility. 15 minute checks is advised. -On 03/07/16 10:49 pm, Resident #2 walked away from facility around 6:00 pm. Resident #2 returned shortly after. Resident #2 walked away from the facility again and said was going to meet the drug dealer, Resident #2 said no one cared why should she. Mobile crisis contacted and documented the responses if she is not harm to self or another one there is nothing we can do about walking off. The mental health team would discuss Resident #2 in the morning during the meeting. -On 03/09/16 at 2:44 pm, Resident #2 walked off the facility property at 1:45 pm after an argument with her boyfriend. She refused to return to the facility with staff. Sent staff to follow her. Mobile crisis, law enforcement and guardian contacted. Sent staff member to follow her until law enforcement showed up. Resident #2 walked into	{D 270}		

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{D 270}	Continued From page 35	{D 270}		

the woods out of staff member's line of view. Management aware of situation.
-On 03/09/16 at 9:00 pm, Resident #2 was taken to ER by law enforcement for evaluation after IVC was petitioned. Resident #2 with behaviors issues on first shift. Mental health provider and guardian contacted.

Review of Resident #2's facility incident reports for the month of March 2016 revealed:
-On 03/06/16 at 6:40 pm Resident #2 walked away from the facility three times. Mobile crisis and the guardian contacted. 15 minute checks are ongoing. Resident #2 refused 5:00 pm and 8:00 pm medications.
-On 03/07/16 at 6:15 pm Resident #2 walked off the facility grounds. Resident #2 returned shortly after and got hat and coat stating she was going to meet drug dealer. Mobile crisis called as well as guardian. Resident #2 returned shortly on her own to the facility.
-On 03/09/16 at 1:45 pm Resident #2 in verbal altercation with boyfriend. Resident #2 walked off facility property and refused to return. Staff member followed her. Notified crisis control, sheriff department, and guardian.
-On 03/09/16 at 3:00 pm with increase agitation and anxiety on first shift. Walked away from the facility. Resident #2 was seen by staff stepping in front of cars. Mobile crisis contacted for petition for IVC. Sheriff Department called and transported Resident #2 to ER for evaluation.

Review of the crisis treatment team meeting minutes for March 8, 2016 revealed:
-Resident #2, the facility, or her guardian were not at attendance.
-Only the ACT team attended and reviewed the crisis plan for Resident #2.
-A copy was provided for all the team members

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{D 270}	Continued From page 36 who attended, and the importance of following the step by step plan were discussed. Review of Resident #2 hospital discharge summary dated 03/09/16 revealed: -Resident #2 was brought the ER for evaluation under IVC. -Resident #2 walked off from the facility property against facility rules, and was stepping in front of cars. -The IVC papers said intentionally stepped in front of cars. Review on the crisis treatment team meeting minutes for March 10, 2016 revealed: -Resident #2 had attended the meeting. -Resident #2 required a place to stay until her new placement arrived "to pick her up." -Rules were discussed with Resident #2 "If she tried to leave the police would be notified." -Discussed with Resident #2 medication problems related to diabetes. -Resident #2 agreed not to leave before her new placement had arrived. -Resident agreed to follow rules "no fighting, drugs, sexual activity." -Resident #2 was being discharged and referred to a new mental health provider. Observation on 03/11/16 at 11:40 am revealed a notebook located in the medication room with Resident #2's crisis prevention and intervention care plan. Review of Resident #2's crisis prevention and intervention plan revealed: -Date of initial plan was 04/09/15. -No date for last revision was documented. -Documented events that caused Resident #2 trouble in the past included, people yelling, abuse	{D 270}		

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{D 270}	Continued From page 37 history, using marijuana, family other than her mother contacting her. -Documented early warning signs for Resident #2 included, staying in her room, not taking medications or eating, sleeping a lot, and not talking to people. -Documented how others can help Resident #2 with early crisis included, talking through my problems, encouragement to take medications. -Documented if Resident #2 is in crisis included, write in journal, talk with staff, make sure I am safe and will not hurt myself, use coping skills and take my medications. Review of Resident #2's record revealed no documentation of a revised 11 step updated crisis prevention and intervention plan in Resident #2's record for review. Interview on 03/11/16 at 3:30 pm with another Medication Aide revealed: -Resident #2 had cut her wrists probably 7 times since her admission, "That is one of her diagnoses." -Resident #2 had come to the medication room with "red streaks" on both arms a month ago. -She was working when Resident #2 had attempted to drown herself in the bath tub. Resident #2 had been upset with her boyfriend and locked herself in the facility common bathroom. I called for another staff to get the key to unlock the bathroom door. When we unlocked the bathroom door we found Resident #2 was naked laying on her back, the water was running and the bath tub was full, Resident #2 was under the water holding her nose. The PCA and I pulled Resident #2 out of the water and Resident #2 said she wanted to drown herself. I told the PCA to stay with the Resident while I called the crisis control team.	{D 270}		

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{D 270}	Continued From page 38 -She was aware of the crisis prevention intervention plan for Resident #2 but, "It's easier to just call them." -Resident #2 was IVC'd the night of the attempted drowning. Review of the Emergency Medical Services (EMS) communication report for Resident #2 on 03/06/16 revealed: -Documentation the facility contacted EMS (911) at 5:49 pm due to Resident #2 had chest pains. -Documentation Resident #2 was red in color but breathing normally. -Documentation Resident #2 had taken a drug in the past 12 hours, "gotten in a car with a man, and he gave her white powder." -Documentation Resident #2 had walked away from the facility again at 6:06 pm. Interview on 03/07/16 at 4:00 pm with the Resident Care Coordinator (RCC) revealed: -She was aware Resident #2 had walked off the facility property on 03/06/16 around 5:45 pm. -Resident #2 came back to the facility in about 15 minutes and left the facility again. -Resident #2 returned and said she had gotten in a car with a man and snorted a white powder. -Resident #2 complained of chest pain, and 911 Emergency Medical Services were called. -Resident #2 left the facility again after EMS were called. -Resident #2 returned with EMS and law enforcement was present. -Resident #2 was checked out by EMS they did not take her to ER, she had refused. -The Guardian was called. -No urine drug screen was obtained for Resident #2. -She was aware Resident #2 had a standing order for UDS but thought it was an old order	{D 270}		

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{D 270}	Continued From page 39	{D 270}		

since it was almost a year old.
-She thought the Nurse Practitioner had discontinued the order for the UDS.
-The staff probably just overlooked the order for the UDS for Resident #2.
-Resident #2 told the sheriff deputy it was a "goody powder" she had snorted on 03/06/16.

Telephone interview on 03/10/16 at 2:30 pm with Resident #2's Medical Provider Nurse Practitioner revealed:
-He was unaware Resident #2 had "snorted the white powder" on 03/06/16.
-He had written a standing order for Urine Drug Screen (UDS) testing on 03/20/15, and expected it to be followed.
-"I definitely wanted the order followed with Resident #2, there is too much of a problem with drugs in the facility."
-He was aware Resident #2 had a UDS completed on 01/04/16 and tested positive for methamphetamines.
-He relied on the facility to follow his orders as written.

Review of the Emergency Medical Services (EMS) communication report for Resident #2 on 03/07/16 revealed:
The facility contacted EMS (911) on 03/07/16 at 6:43 pm due to "two residents left the facility and were at the church waiting on narcotics to be dropped off to take back to the facility."
-Documentation Resident #2 was named as one of the residents waiting at the church for narcotics.
-Documentation "the same thing happened yesterday and the female consumed them before entering the facility."
-Documentation the facility called EMS 911 at 7:05 pm and reported to cancel the call due to

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{D 270}	Continued From page 40 both residents returned to the facility. Interview on 03/07/16 at 11:20 am with Resident #2 revealed: -She lived at the facility since January or February 2015. -Sometimes when she left the facility, staff did not follow her. -She goes straight to the drug dealer's house and they give her drugs. -It was not a house, but a blue trailer up the road from the facility to get drugs. -She had never stayed the night at the trailer. -It had been a couple of months since she went to the blue house for drugs. -She believed that her guardian was aware she used drugs. -On Saturday and Sunday (March 5th and 6th, 2016) she left for a few hours and went to the "blue trailer." They sell pretty much everything. Interview on 03/07/16 at 4:01 pm with a 2nd shift Personal Care Aide (PCA) revealed: -Resident #2 was mainly in her boyfriend's room, even when he asked her to leave, she would not leave. -Resident #2 even faked having seizures to go to the hospital. -Resident #2 used to go to the blue "house" down the road, but she thought now they would not deal with the resident. Interview on 03/07/16 at 4:16 pm with a second, 2nd shift PCA, revealed: -On Sunday, March 6, 2016 Resident #2 left the facility 5-6 times. -The resident refused to go to the hospital. -The resident left the facility and did not go far, she stood by the church, near the circle in the road.	{D 270}		

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{D 270}	Continued From page 41 -Resident #2 does try to hurt herself, sometimes facility staff catch her or the resident will come and show staff how she hurt herself. Interview on 03/07/16 at 4:30 pm with a third, 2nd shift PCA revealed: -Resident #2 and her boyfriend were always yelling and arguing. -Resident #2 leaves and comes back, most times she came back before dark, if staff did not go after her. -"To be honest sometimes staff went after Resident #2, but sometimes staff did not know she was gone." Interview on 03/07/16 at 5:00 pm with the Operations Manager revealed: -Resident #2 was usually the one who provoked her boyfriend. -Today Resident #2 told her about things that happened over the weekend, emergency responders were called, and mobile crisis was called. -The resident's guardian would have to order a drug screening. -She was aware that Resident #2 tested positive for methamphetamines about a month ago. -She was aware of Resident #2's incident on 03/06/16 and Resident #2 leaving the facility. Telephone interview on 03/08/16 at 11:30 am with Resident #2's Guardian revealed: -He was the legal guardian for Resident #2 for over one year. -He was aware Resident #2 had multiple incidents at the facility involving harm to self, leaving the facility, assault on another resident, on probation due to the assault, leaving the facility to get drugs, altercations with boyfriend and sexual behaviors.	{D 270}		

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{D 270}	Continued From page 42 -He stated, "Resident #2 is always into something." -Resident #2's team treatment care plan meetings are monthly and involved the guardian, the mental health providers, the physician, the facility, and Resident #2. -Resident #2 had an 11 step crisis plan the mental health providers had established and updated during the care plan meetings. -Resident #2 was in the process of being moved from the facility due to "The facility is not the right place for Resident #2." -Resident #2 needs to be closer to her family and myself. Interview on 03/08/16 at 12:45 pm with a first shift PCA revealed she was unaware where Resident #2 was but was aware Resident was on 15 minute checks. Telephone interview on 03/07/16 at 2:10 pm with a local Sheriff's Department Deputy revealed: -He had been called out to the facility hundreds of times. -He was aware Resident #2 had altercations and walked away from the facility multiple times. -He was aware of a "blue trailer" drug house near the facility. Telephone interview on 03/08/16 at 2:30 pm with the local narcotic agent revealed: -He was aware of a "blue trailer" drug house near the facility and had spoken to the facility nurse with this concern. -There had been methamphetamine activity in the area last summer which included a death related to methamphetamines. Interview on 03/08/16 at 2:50 pm with a mental health Nurse Practitioner for Resident #2	{D 270}		

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{D 270}	Continued From page 43 revealed: -He said Resident #2 had "a lot of issues with her boyfriend." -Resident #2 had several IVC's due to the altercations and arguing with the boyfriend. -Included in a hospital discharge of 02/21/16, a new diagnoses of Post-Traumatic Stress disorder was added to Resident #2's medical profile. -Resident #2 was a challenge. -He was aware of Resident #2's behaviors which included leaving the facility looking for drugs, cutting herself, and her probation due to the assault on another resident. -He was aware of the blue trailer "drug house" and it had been discussed in monthly meetings with all Resident #2's team member's involvement. -He was unaware Resident #2 had stayed the night in another resident's (boyfriend) room on 03/07/16. -Resident #2 had "burned a lot of bridges" in multiple group home and assisted living facility. -"I feel a locked unit is more appropriate for Resident #2." Interview on 03/08/16 at 3:20 pm with Resident #2's boyfriend revealed Resident #2 had stayed the night on 03/07/16 in his room watching television. Interview on 03/08/16 at 3:25 pm with a fourth second shift PCA revealed: -Resident #2 had stayed in another resident's (boyfriend) room on 03/07/16. -The facility rule is at 10:00 pm all resident must be in their own room. -Resident #2 is "not easy to deal with." Interview on 03/08/16 with Resident #2 revealed: -She stayed in another resident's (boyfriend)	{D 270}		

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{D 270}	Continued From page 44 room on 03/07/16. -Staff was aware I stayed in his room all night. -"I did not have sex with him only watched TV." -I leave the facility when I get mad at my boyfriend. -"I am a crack head." Interview on 03/08/16 at 3:45 pm with the roommate of Resident #2's boyfriend revealed: -He shared a room with Resident #2's boyfriend. -He was aware Resident #2 had stayed all night in his room with his roommate on 03/07/16. -He had stayed awake in the activity room all night watching television and listening to music. -Resident #2 had stayed overnight with the boyfriend before many times. -He was never told not to come in his room, but felt uncomfortable with Resident #2 in his room. -He did not like Resident #2. Review of the facility house policy rules revealed: -Opposite sex friends or opposite sex residents are not allowed in semi-private rooms at any time, unless the reason has been discussed with the Administrator. -Residents that have a private room may have visitors, family, or case managers in their room between the hours of 10:00 am and 8:00 pm. -It is prohibited for residents to sleep or take up residence in any room other than the room assigned to them on admission. -Failure to follow the rules can result in discharge from the facility. Review of Resident #2's record revealed a copy of the facility house policy rules were signed by Resident #2's guardian and dated 02/25/15. Telephone interview on 03/09/16 at 11:05 am with Resident #2's probation officer revealed:	{D 270}		

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{D 270}	Continued From page 45 -Resident #2 had assaulted her roommate in November 2015 and the court ordered probation. -He was aware both residents were currently living in the facility. -He had obtained a random Urine Drug Screen for Resident #2 in January 2016 and it was positive for methamphetamines. -She was not allowed to leave the facility without permission, "that is the facility rules." -"There is not much I can do if she leaves the facility, but if she stays gone then I would do something." -At the team care plan meeting in January 2016, moving Resident #2 was discussed. -He was aware of the drug house (blue trailer) near the facility. -Resident #2 is not in the proper facility. -Resident #2 needs to get inpatient treatment that is required for her illness. -"I think she needs a locked unit." Observation on 03/09/16 between 1:45 pm and 2:40 pm of Resident #2 revealed: -Resident #2 was seen by survey team walking up the road past the church approximately 1/10 of a mile from the facility. -No facility staff were present with Resident #2. -Facility staff were standing at top to the facility driveway watching Resident #2 and yelling for Resident #2 to come back to the facility. -Resident #2 turned around when she saw the surveyors' state car and proceeded to walk back toward the facility. -The state surveyors drove past the facility and turned the car around. -Resident #2 was seen walking in the opposite direction (toward blue trailer) away from the facility on right side of road and Resident #2's boyfriend was walking on the left side of road. -No staff were walking with Resident #2, but a	{D 270}		

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{D 270}	Continued From page 46 facility van was following approximately 30 yards behind both residents. -Approximately 2:30 pm a local sheriff's car pulled into the facility parking lot and was getting a report of the incident from the OM. -The van driver returned to the facility without Resident #2. Interview on 03/09/16 at 2:38 pm and on 03/15/16 at 2:30 pm with the facility van driver revealed: -He had left Resident #2 at the church on 03/09/16, "she refused to get into the van". -He was in communication with the facility via cell phone. -He was told by the MA that the sheriff deputy was on his way. -He was told by a Medication Aide (MA) to return to the facility. -When a resident left the facility without permission, he followed them in the van and usually stayed with the resident until the sheriff deputy arrived. -It was a "communication problem" on 03/09/16 and that was why he returned without staying with Resident #2. Telephone interview on 03/09/16 at 3:10 pm with Resident #2's guardian revealed: -He was called on 03/09/16 about Resident #2 leaving the facility property. -He was told staff was with Resident #2 and staff had stayed with Resident #2 at all times Resident #2 was off the facility property. -He was not aware the facility van driver had left Resident #2 without supervision while the sheriff deputy was getting a report at the facility. -Resident #2 had another facility that had accepted her today, she would be moving ASAP. Interview on 03/09/16 at 3:30 pm with a second	{D 270}		

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{D 270}	Continued From page 47 shift Medication Aide revealed: -Resident #2 had left the facility property multiple times. -On 03/09/16 Resident #2 had been observed by the facility staff, "jumping in front of cars." -Resident #2 is very mean to staff cursing us all the time. -"We cannot accommodate Resident #2's needs." Interview on 3/10/16 at 9:45 am with a first shift MA revealed: -She was working on 03/09/16. -Resident #2 had become upset and walked away from the facility property. -She called the van driver to follow Resident #2. -She and another MA went to the top of the facility driveway to watch Resident #2 on 03/09/16. -Resident #2 had run into the woods behind the church out of our sight. -She had seen the state car on 03/09/16 pass the church and then Resident #2 turned around, headed back toward the facility. -Resident #2 walked by her and past the facility and told her, "I am going to leave this ...place." -She called the van driver again and told him to follow Resident #2. -Resident #2 went to the church (near the blue trailer) and the van driver followed them. -The van driver told me the sheriff deputy was at the scene, so I told the van driver to return to the facility. -She was unaware the sheriff deputy was in the facility parking lot obtaining a report of the missing person, not with Resident #2. -She was unaware Resident #2 was left unsupervised on 03/09/16 prior to the deputy arriving at the scene. -She did contact Resident #2's guardian and informed him Resident #2 was "getting into traffic, that's not safe."	{D 270}		

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{D 270}	Continued From page 48 Interview on 03/10/16 at 9:50 am with a second first shift MA revealed: -She worked on 03/09/16 when Resident #2 walked away from the facility. -The van followed Resident #2, but Resident #2 ran into the woods. -Resident #2 was "jumping out in front of vehicles." -Resident #2 was sent to the ER for evaluation on 03/09/16 and she was unsure of Resident #2 current status. Interview on 03/10/16 at 10:00 am with the Operations Manager (OM) revealed: -She was aware the van driver returned to the facility on 03/09/16 without Resident #2. -There was a miscommunication between the MA and the van driver. -The MA thought the sheriff deputy was with Resident #2. -She had given the sheriff deputy a report of the missing person (Resident #2) in the facility parking lot when the van driver returned. -Resident #2 was in the ER and her guardian had informed her that Resident #2 was not coming back to the facility. -The guardian had found placement for Resident #2 in another county near Resident #2's family and himself. -She had talked to the guardian and mental health providers many times to discuss discharging Resident #2. -She had documented the multiple times she had spoken to Resident #2's guardian about discharge. Based on observations, interviews, and record reviews revealed the documents of the OM of speaking to Resident's #2's guardian concerning	{D 270}		

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{D 270}	Continued From page 49 discharge were not made available during the survey from 03/07/16 to 03/16/16. Interview on 03/11/16 at 11:30 am with the facility RCC revealed: -She was aware Resident #2 had walked off the facility property on multiple occasions. -She was aware Resident #2 was on probation. -She was aware Resident #2 had several attempts to harm-self which included Resident #2 cutting herself, attempted to choke herself with electric cord, attempted to harm self with scissors and the drowning attempt in the bathtub. -Resident #2 was on 15 minutes checks since February 2016 and maybe before even before that. -Resident #2 had a mental health 11 step crisis plan, "We follow our part." Interview on 03/16/16 at 9:00 am with a Mental Health case manager for Resident #2 revealed: -The treatment team were focusing on safety, coping seeking skills, and motivation with Resident #2's treatment. -Resident #2's relationships are a key trigger for the behaviors issues. -She was aware and present in the facility when Resident #2 tried to cut her throat with scissors. -I think, "Resident #2 wanted her boyfriend to see the police take her out." -She did strengthen Resident #2's crisis and intervention plan, but not sure of the date. -She was not able to get to the facility on 03/09/16 for the IVC petition. -She was aware guardian had accepted placement for Resident #2 in another county closer to family. -On 03/09/16 the ER did not admit Resident #2, only held for 24 hours.	{D 270}		

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{D 270}	Continued From page 50 Interview on 03/15/16 at 4:00 pm with a second sheriff's deputy revealed: -Resident #2 walked away from the facility multiple times. -Resident #2 had arguments with her boyfriend which caused most of the problems. -"The facility cannot supervise the residents they have in the facility." -The facility calls us after the residents leave the facility, sometimes up to 1 hour after. -"It takes the county deputies away from the community which needs our services." Telephone interview on 03/14/16 at 9:00 am with Resident #2's guardian revealed: -Resident #2 had stayed at the hospital overnight on 03/09/16. -She was not admitted to the hospital on 03/09/16 and was cleared for transfer on 03/10/16. -He had a problem with the facility not communicating with me or sending me the incident reports I had requested involving Resident #2. -He started looking for placement for Resident #2 after reading the state annual report on the web site. -He felt the facility did have a problem with drugs and Resident #2 was not in the proper place. -The only time discharging Resident #2 was discussed by the facility was December 2015, at the care plan team meeting. -The facility had not attended the January 2016 care plan meeting. -The facility would not discharged Resident #2 if he had not found placement for Resident #2. -He called the OM on 03/09/16 and informed her that Resident #2 would be moving to another facility on 03/10/16. -The OM sent me an email on 03/09/16 at 4:30 pm discharging Resident #2 from the facility.	{D 270}		

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CEDARBROOK RESIDENTIAL CENTER	1267 PINNACLE CHURCH ROAD NEBO, NC 28761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 270}	Continued From page 51 -Resident #2 had been moved on 03/10/16 to a family care home close to Resident #2's family and himself. Interview on 03/11/16 at 11:15 with the OM revealed: -The facility does not have a written policy for supervision of the residents. -Resident #2 was on 15 minute checks, but never on 1 on 1 staff monitoring. -Resident #2 had been relatively calm until last week. -Resident #2 was more difficult to redirect when with her boyfriend. -She was not working when Resident #2 had the altercation with her roommate, but would get the incident report to the survey team. -Resident #2 had a mental health crisis safety plan and staff was aware of the plan, but the staff does not do the safety plan. -She was aware Resident #2 had left the facility property on 03/06/16 and gotten into a car with a man, but was not aware Resident #2 told staff she snorted a white powder. -On 03/09/16 Resident #2 refused to return to the facility with the van driver. - The van driver should had stayed with Resident #2 until the sheriff deputy arrived on the scene but, "It was a communication issues." -She was familiar with Resident #2's attempt to choke self with electrical cord, but not the drowning attempt. -Staff did not inform her of the drowning attempt. Interview on 03/16/16 at 2:30 pm with another MA revealed: -We are doing 15 minute checks on Resident #2, "we lay eyes on her." -We follow Resident #2 when she leaves the facility, if we know she is gone.	{D 270}		

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{D 270}	Continued From page 52 -Resident #2 will walk off the facility property sometimes and not return. -"We take a car and follow her (Resident #2), if we know she is gone." Review of the facility's 15 minute checks documentation for Resident #2 revealed: -A facility document listed Resident #2's name at top of page. -The document was for an 8 hour shift. -The staff documented every shift on the top line with initials and a line was drawn down the page to the end of the 8 hour shift. - A location and activities column was on the right side for documenting Resident #2's location every 15 minutes. -Staff documented in the location column at the top of the page, under time 3:00 pm to 3:30 pm "hallway, med-room, room" for 03/07/16 no further documentation was noted for the 8 hour shift. -No documentation in the location column on 03/06/07 between 3:00 pm and 4:45 pm. -Documented on 03/06/16 Resident #2 location at 5:00 pm "walked off", at 5:30 pm "back", at 6:00 pm "room", at 6:45 pm "left", at 7:30 pm "back", at 8:00 pm "room", and at 8:45 pm "bed" no further documentation for the 3:00 pm to 11:00 pm shift of the location of Resident #2. B. Review of Resident #22's current FL2 dated 07/09/15 revealed: -Diagnoses included schizophrenic disorder and alcohol abuse. Review on 03/15/16 at 10:45 am of Resident #22's record revealed he had a legal guardian. Telephone interview on 03/15/16 at 8:15 am and at 4:00 pm with a local Sheriff Deputy revealed:	{D 270}		

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{D 270}	Continued From page 53 -He had received a call on 03/14/16 concerning Resident #22 was missing from the facility. -Resident #22 had walked away from the facility two hours prior to receiving the call. -Resident #22 left the facility around 12:30 pm and he did not get the call until around 2:45 pm. -He found Resident #22 walking on the Interstate toward exit 90. -He estimated Resident #22 had walked 4-6 miles from the facility. Review of the facility sign out log for 03/14/16 revealed Resident #22 had not signed out on 03/14/16. Review of the facility Meal Time Census Worksheet revealed Resident #22 was not accounted for on 03/14/15 at 12:30 pm for the lunch meal head count. Interview on 03/15/16 at 11:45 am with the day shift Kitchen Supervisor revealed: -She had worked on 03/14/16. -At every meal the MAs completed a facility meal time census worksheet to account for all the residents in the facility. -The meal time census lets us know if a resident is not at lunch or not in the building. -The MA told me to put back 3 lunches on 03/14/16 and one was for Resident #22. -The MA's file the worksheet and give to the SIC for review. Interview on 03/15/16 at 11:50 am with a PCA revealed: -We do a headcount 3 times a day 8:00 am, 12:30 pm and 6:00 pm. -Resident #22 was not at lunch on 03/14/16 at 12:30 pm, I told the kitchen to put a plate back in the kitchen for him.	{D 270}		

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{D 270}	Continued From page 54 -I found out Resident #22 was not in the building then at 12:30 pm, and told the MA. Interview on 03/15/16 at 12:00 pm with the MA revealed: -She was aware Resident #22 was missing at lunch and at the 1:00 pm medication pass. -The SIC called the sheriff department sometime before the 1:00 pm medication pass was completed. Review of the Emergency Medical Services (EMS) communication report for Resident #22 dated 03/14/16 revealed: -The facility had contacted EMS at 1:53 pm and reported a missing person (Resident #22). -The facility staff reported last seeing Resident #22 at 12:30 pm. -The facility staff reported Resident #22 had a diagnoses of Schizophrenia. -The sheriff's deputy returned Resident #22 to the facility at 2:46 pm. Telephone interview on 03/15/16 at 10:45 am with Resident # 22's guardian revealed: -The facility had called her around 2:00 pm about 30 minutes after Resident # 22 had left the facility. -She was unaware Resident #22 was found on the Interstate. -The facility staff did not call me when Resident #22 returned to the facility. -Resident #22 called his guardian when he returned to the facility. -The guardian said Resident #22 was trying to get to exit 90, but she had no idea he was found walking on the Interstate. -"The Interstate is a very dangerous road." Review of the facility charting notes for Resident	{D 270}		

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{D 270}	Continued From page 55 #22 revealed: -Resident #22 was not located during head-check at 1:40 pm. -The Sheriff's office and the Guardian were called. -Resident #22 was returned at 2:45 pm via sheriff vehicle. -it was documented the guardian was notified of Resident #22 return at 2:45 pm. Interview on 03/15/16 at 4:30 pm with Resident #22's Mental Health Nurse Practitioner revealed: -He was aware Resident #22 had walked away from the facility and was located by the sheriff deputy walking on the Interstate on 03/14/16. -Resident #22 had been stressed due to his girlfriend being discharged from the facility. -Resident #22 might not be taking his medication or "pocketing" his medications. -He said Resident #22 did not have a history of pocketing his medications. -Resident #22 had left the facility before, trying to get to exit 90. -"It's a long way to the interstate, and very busy traffic." -My plan is to place Resident #22 in an inpatient setting for 7-10 days and return to the facility if appropriate. Interview on 03/15/16 at 3:50 pm with Resident #22 revealed: -He had left the facility sometime before lunch and did not sign out on the facility sign out book. -He just wanted to walk, no one tried to pick him up. -He was trying to get to the truck stop on the Interstate, but did not know why he was trying to get there. -He was in trouble for not signing out on 03/14/16.	{D 270}		

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{D 270}	Continued From page 56 -He had talked to his guardian on 03/14/16 but did not tell her he was found by the sheriff deputy walking on the Interstate. C. Review of Resident #9's current FL2 dated 09/01/15 revealed: -Diagnoses included mild retardation, Turner's syndrome, left side hemiparesis, mood disorder, and partial blindness. Review of Resident #9's record revealed the resident was deemed incompetent and had a court appointed guardian. According to the guardianship order Resident #9's was not allowed to make decisions without the guardian's knowledge. Review of Resident #9's Resident Register revealed an admission date of 09/08/14. Review of Resident #9's Care Plan signed by the physician on 08/04/15 revealed: -The document was prepared by the Resident Care Coordinator (RCC). -There was no documentation the resident was currently receiving medication for mental illness/behaviors. -There was no documentation the resident had a history of mental illness. -There was no documentation the resident was currently receiving mental health services nor an agency name documented. -The RCC documented the resident had to be redirected at times, had problems going into other residents rooms without permission, and tends to become "attached" to staff. -The resident needed supervision when eating, was independent with toileting, ambulation, bathing, dressing, grooming and transferring.	{D 270}		

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{D 270}	Continued From page 57 Review of Resident #9's progress notes revealed: -01/05/16 at 3:19 pm, Resident #9 went to a male resident room with a cup of cold water and threw it on him. -01/06/16 at 4:33 pm, Resident #9 was caught in a male resident room who was fondling her. Resident put on increased supervision (no documentation of the type of increased supervision). -01/24/16 at 8:43 am Resident #9 went into a male resident's room and stole $2.00, then lied about it, and threw it on the floor. -01/28/16 at 1:17 pm, another resident reported that Resident #9 was in a male resident's room hitting him with a blanket and throwing water on him. Interview on 03/09/16 at 4:15 pm with both Medication Aides on the second shift revealed they were unable to validate increased supervision for Resident #9 on the second shift on 01/06/16. -To their knowledge Resident #9 had never been put on increased supervision on the second shift. -If Resident #9 had been put on increased supervision it would be documented in the supervision check sheets. Review of documented supervision check sheets for the month January 2016 revealed no documentation Resident #9 received extra supervision on 01/06/16, or any date in the month of January 2016. Confidential interview with a male resident revealed: -Resident #9 prostituted herself for "sodas". -He had not seen Resident #9 having sex, but the men she had been with, talked about having sex with her for drinks.	{D 270}		

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{D 270}	Continued From page 58 -Two days ago Resident #14 told him that he "pimped" Resident #9 with sex for a soda. Interview on 03/09/16 at 3:12 pm with Resident #19 revealed: -He lived at the facility for almost 2 years. -Resident #9 was good friend; he had intercourse with Resident #9. -It's been "awhile" since he had intercourse with Resident #9, at least a month. -He did not use protection (condom) when he had intercourse with Resident #9. -He did not feel there was a need to use protection "I don't need it." -He was aware that Resident #9 had sexual relations with other male residents, but he did not care about that. -He was unaware if the facility provided education regarding using protections when engaging in sexual activity. -He had sex with Resident #9 at least 2-3 times, all sexual activity was in his room when the roommate out of the room. Interview on 03/11/16 at 11:50 am with Resident #9 revealed: -She did not have sexual relations with any one at the facility, physical or oral. -She did have condoms in the drawer in her room, but did not use them. Interview on 03/09/16 at 3:30 pm and 03/11/16 at 3:06 pm with a second shift Personal Care Aide (PCA) revealed: -Two weeks ago (February 2016) she saw Resident #9 and #19 engaged in intercourse. -She broke it up, and had Resident #9 to leave the room. -She did not tell anyone because Resident #9's guardian said it was okay for her to have sex.	{D 270}		

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{D 270}	Continued From page 59 -She had not seen the resident in any sexual activity since. Interview on 03/15/16 at 3:50 pm with Resident #19's former roommate revealed: -On two occasions in January 2016 and mid-February 2016, he walked in the room and caught Resident #19 and Resident #9 engaged sexual activity. -He did not say anything, but left the room until they had finished. -He had not seen Resident #9 with anyone else but Resident #19. -He had not heard about Resident #9 being with others, only Resident #19, he did hear that Resident #9 stole from others. -Everyone still complains about Resident #9 stealing, staff does nothing about her stealing. Interview on 03/15/16 at 2:56 pm with the transportation driver/housekeeper revealed: -Last week, she took Resident #19 to the doctor's office. -When the nurse asked Resident #19 if he had blood transfusion or sex with anyone lately, she heard Resident #19 tell the nurse that he had sex with Resident #9. -Resident #19 stated he did not have sex with anyone else, only Resident #9. -Prior to hearing Resident #19 say he had sex with Resident #9 she was unaware that Resident #19 was sexually active with Resident #9. -She did not report Resident #19 saying he had sex with Resident #9. Interview on 03/07/16 at 11:20 am with Resident #2 revealed: -There was lots of sex for cigarettes going around the facility. -There were certain people doing that, but she did	{D 270}		

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{D 270}	Continued From page 60 not want to reveal their names. -The staff on the first shift were aware residents were having sex for cigarettes, but did nothing. -She was not sure if second shift was aware, because "you can't ever find them." Interview on 03/10/16 at 10:01 am with a first shift Medication Aide/Personal Care Aide revealed: -They had a meeting that if anyone saw Resident #9 engaged in sexual activity, they were to call the guardian and put the resident on 15 minute checks. -Resident #9 does steal and was often in rooms stealing. -If Resident #9 goes into other residents' rooms, the resident will usually yell loud enough for staff to hear because they know that Resident #9 steals and don't want her in their room. -She had not seen Resident #9 in any sexual activity since last year. Confidential individual interviews with three residents revealed: -Two residents revealed Resident #9 was selling sex every day, the going price was $2. -One resident said Resident #9 mostly did oral sex, and engaged in oral sex with his former roommate. Resident #9 will have sex any given day or hour, she just needs money, and facility staff was aware of what Resident #9 was doing. -One resident said he was warned by other residents about having sex with Resident #9 when they first came to the facility in December 2014. -A third resident said Resident #9 was one of the "girls" selling herself for soda and $2.00. He knew the men that said Resident #9 had sex with them, but did not want to reveal their names. Interview on 03/14/16 at 1:05 pm with the Medical	{D 270}		

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{D 270}	Continued From page 61 Nurse Practitioner revealed: -She was aware that Resident #9 had behavior issues, but not specific behaviors. -In December 2015, she was aware Resident #9 had increased behaviors and wrote a note for a psychiatry consult secondary to behaviors. -She was unaware that Resident #9 was selling herself for soda and money. Interview on 03/15/16 at 4:20 pm with the Mental Health Nurse Practitioner revealed: -Resident #9 was manipulative. -In January 2016, Resident #9 was very "mean." -Resident #9 had attacked other residents, destroyed facility furniture, and damaged a female staff member's vehicle. -Resident #9 wrote love letters to female staff members that described how she wanted to have sex with the staff members. -Resident #9 had damaged a female staff member's vehicle because the resident was upset when the staff member told the resident "no" regarding love letters written by the resident that involved having sex with the female staff member. -He thought Resident #9 would do better in a smaller facility, definitely with no men, however due to the resident writing love letters to staff he was not sure. -He tried medications to handle Resident #9's aggressive behaviors in hopes medications will also help with sexual activity. -As of today he wondered if Resident #9 was having some mental impairment memory loss, and was truly forgetting incidents as though they did not occur in her mind. Interview on 03/11/16 at 11:45 am with the Operations Manager revealed: -She was not aware that Resident #9 was	{D 270}		

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{D 270}	Continued From page 62 sexually active. -She was aware the resident was friendly, and another female resident complained that Resident #9 keeps talking to her boyfriend. Second interview on 03/16/16 at 2:35 pm with the Operations Manager revealed: -She was not aware of the information supplied by the Mental Health Nurse Practitioner that Resident #9 wrote love letters to female staff asking for sex. -She was aware that Resident #9 had a special friendship with two staff members, a Personal Care Aide (PCA) on the third shift, and a Medication Aide (MA) on the first shift. -In January 2016, Resident #9 had behavior issues and followed the PCA around the facility, but she was not aware Resident #9 damaged the staff member's car. -She saw one of the letters that Resident #9 had written to the MA and she did not recall seeing anything related to having a sexual relationship with the staff. -She had observed Resident #9 wrote on her (bedroom) door "Resident #9 + MA=BFF's". -She did not recall staff complaining about Resident #9 sending the letters. Interview on 03/16/16 at 3:55 pm with the first shift Medication Aide (MA) revealed: -Resident #9 does not tell the truth, don't believe anything she said. -Since Resident #9 moved into the facility a year and half ago, "she started writing love letters to me." -The love letters were not friendly, "she (Resident #9) talked about having physical sex with me." -Every week she was given a letter by Resident #9. -She had several meetings with the Operations	{D 270}		

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{D 270}	Continued From page 63	{D 270}		

Manager, the Administrator, and Adult Home Specialist regarding the sexual love letters.
-Last summer every day when she left work Resident #9 would sit a chair behind her car so she could not move unless she spoke to the resident.
-The resident still waits for her by the time card machine.
-When she comes to work she still had to move fast to get in the medication room away from Resident #9.
-Currently, Resident #9 was in her face wanting to talk.
-She told Resident #9's guardian, but the guardian does not care about Resident #9, she acts like the resident is not her problem.
-Once when the County DSS Adult Home Specialist was at the facility, Resident #9 handed her a love letter, and the Adult Home Specialist saw what the resident wrote in the letter.
-All management was aware that Resident #9 wrote her love letters that were sexually involved.
-Previously, Resident #9 was doing the same to a male staff that worked in the kitchen.
-The staff person got so tired of it that he quit.

Attempted interview with the PCA on third shift (vehicle was damaged by Resident #9) was unsuccessful.

Interview on 03/10/16 at 9:19 am with Resident #9's guardian revealed:
-She could not be at the facility 24/7 with the resident to physically stop Resident #9 from having sex, "there is no way to stop her."
-She felt that facility staff was unable to catch the resident when engaging in sexual activity, so she let the resident make her decisions regarding having sex.
-She requested not be notified of Resident #9's

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CEDARBROOK RESIDENTIAL CENTER	1267 PINNACLE CHURCH ROAD NEBO, NC 28761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 270}	Continued From page 64	{D 270}		

sexual encounters.
-No comment was made about the resident possibly contacting a sexually transmitted disease.
-The guardian's comment when asked if she was aware Resident #9 had sex for money and soda, was "I can't be there 24/7 to stop her."

Interview on 03/11/16 at 3:12 pm and 3:35 pm with the Resident Care Coordinator (RCC) revealed:
-Mental health had not given any direction what to do if staff finds Resident #9 in a sexual encounter.
-Staff had been instructed by her to redirect the resident, but the guardian does not want to be notified.
-She was unaware that Resident #19 had been engaged in sexual activity with Resident #9 two weeks ago.
-Although staff were not aware Resident #19 has a communicable disease, they still should have reported the incident to her.

Interview on 03/11/16 at 4:30 pm with a Mental Health counseling provider revealed:
-They stopped counseling services for Resident #9 in December 2015.
-Currently, the resident was being seen by their nurse practitioner monthly for medication management.
-They had been working on the resident's frustration to attempted romantic encounters with facility staff.
-In general for Resident #9 they left the decision of sexual behaviors up to the resident's guardian.

Confidential interview with a female resident revealed:
-Facility staff (Aides and Housekeeping) tried to

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{D 270}	Continued From page 65 tell Resident #9 not to prostitute herself. -She heard a previous male staff tell Resident #9 not to have sex, shortly afterwards he no longer worked at the facility. -She heard first shift staff tell Resident #9 to stay away from Resident #15. -Resident #9 was caught with another male resident and shortly after the resident was discharged from the facility. Resident #15 was not available for interview. Confidential interview with another female resident revealed: -Resident #9 was a thief and sells herself for $2.00. -Resident #9 will not tell the truth, even when you catch her in the act. -She had seen Resident #9 in the bathroom with Resident #19 and Resident #15. -This past Saturday (March 5, 2016), she observed Resident #9 go to the bathroom around 6:30-7:00 pm with two male residents, they were getting oral sex. -Resident #9 usually had sex with Resident #19, Resident #16, and Resident #17. -She usually observed Resident #9 go into the bathroom with these men. Review of Resident #9's record failed to reveal a plan of safety to ensure safe sexual practices. Based on interviews and record reviews no supervision was provided for Resident #9 to ensure her safety when engaging in sexual activity. _____ The failure of the facility to provide a safe environment for residents in regards to the	{D 270}		

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{D 270}	Continued From page 66 supervision needed created opportunities for for Resident #2, who has a known history of suicide attempt, to deliberately inflict self-harm multiple times and failed to implement interventions to protect the resident from further self-injury and suicide attempts resulting in serious neglect; Resident #9, who has been adjudicated incompetent or who due to the resident's diagnoses lacks the ability to make safe decisions independently, to engage in sexual behaviors detrimental to the resident's health and safety and allowed Resident #9 to be sexually exploited by other residents resulting in serious neglect and exploitation; and for Resident #22, who had a legal guardian, to walk 4 to 6 miles from the facility, including along an interstate, unsupervised when the resident was not to leave the facility grounds without supervision resulitng in serious neglect. _____ The facility did not provide an acceptable Plan of Protection to provide supervision for residents or a date of expected compliance. A Directed Plan of Protection was issued to the facility on 3/18/16. THE DATE OF CORRECTION FOR THE UNABATED TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 16, 2016.	{D 270}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	{D 273}		

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{D 273}	Continued From page 67 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on interviews and record reviews the facility failed to ensure contact with Medical Nurse Practitioners or Mental Health Nurse Practitioners for 3 of 9 sampled residents (Residents #2, #3, and #19) regarding aggressive behaviors and current alcohol and drug use (#3); reporting of sexual behaviors without precautions of spreading a communicable disease (#19); and testing of illegal drug use when suspected (#2). The findings are: A. Review of Resident #3's current FL2 dated 09/17/15 revealed: -Diagnoses included hypertension; major depression; recurrent psychosis; alcohol use disorder; and cannabis use disorder. Review of the Resident Register revealed the resident was admitted to the facility on 09/17/15. Review of Resident #3's Personal Care physician authorization and care plan prepared by the Resident Care Coordinator (RCC) and signed by the Nurse Practitioner (NP) on 10/06/15 revealed: -The resident required supervision with eating - no explanation why. -The resident was currently receiving medications for mental illness/behavior (no medications or behaviors listed on the care plan). -The resident had a history of mental illness he was currently receiving mental health services, but no agency was named.	{D 273}		

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{D 273}	Continued From page 68 -The resident had a history of substance abuse. -"Per history, if the resident drinks alcohol he can become verbally and physically aggressive, has not consumed alcohol while at facility." 1. Review of charting notes for Resident #3 revealed: -01/10/16 at 10:30 pm, Resident #3 had increased agitation, stating he needed to get out of the facility. -01/21/16 at 10:17 pm, Resident #3 walked off from the facility on the 1st shift. An off duty staff member reported seeing the resident at nearby trailer asking for rides to return back to the facility, and Resident #3 seemed to be under the influence. The resident came to the med room cursing and demanding narcotic medication. -01/24/16 at 4:59 pm, Resident #3 was involved in verbal altercation with a female resident. -03/07/16 at 10:51 pm, Resident #3 walked off from the facility while arguing with a female resident. -03/12/16 at 2:19 pm, Resident #3 screaming and yelling since he came from a walk (no documentation how long or what the resident was yelling). Interview on 03/15/16 at 2:45 pm with the Mental Health Nurse Practitioner (MHP) revealed: -He visited the facility every other week. -When he visited facility staff will sometimes tell him what was happening with residents. -He was unaware Resident #3 recently started drinking and possible drug use because no one had informed. -No one had given him any information about Resident #3's behaviors prior to today. -Today, he was informed by staff of an incident that happened over the weekend, but prior to that he was unaware of incidents with Resident #3	{D 273}		

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{D 273}	Continued From page 69 being agitated and under the influence. -Facility staff had made him aware that Resident #3 got in arguments with his girlfriend (a resident at the facility), but he was unaware Resident #3 had incidents of hitting or throwing things at her. -Today, he tried several times to talk with Resident #3, but he refused to talk to him. -He would have like to known those things because he thought Resident #3 was doing very well. Interview on 03/16/16 at 2:30 pm with two first shift Medication Aides revealed: -On 03/12/16 Resident #3 was upset and signed himself out. -"Wherever he went, he got into drinking." -The law enforcement called the facility and informed they had multiple complaints from the community about the Resident #3 (not sure what type of complaints). -Resident #3 returned to the community around 1:15 pm, and wanted his narcotics medication. -The medication was scheduled every four hours and she couldn't give one. -Resident #3 was constantly screaming yelling at anyone, everything. -He called one female resident a "MFB" and she called him a "whore." -Resident #3 came to the medication room and apologized the MA four times, but was still upset. -At 4:05 pm Resident #3 signed out again, screaming that he was going to give certain people a piece of his mind, and the first chance he got he was getting out of this place. -Resident #3 also expressed he was angry at his primary care physician for switching his medication times so medications not overlap. -One MA smelled alcohol on Resident #3's breath, the other MA nose was stopped up and she could not smell.	{D 273}		

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{D 273}	Continued From page 70 -They tried to calm the resident down, there was nothing they could do except call mobile crisis. -The MA called the Operations Manager and mobile crisis. -Mobile crisis had no one available, so the MA did not know if anyone from mobile crisis came to see Resident #3 because her shift ended and they would have come on third shift. -One MA said she had only seen Resident #3 like that 1 or 2 times since he returned to the facility in September 2015. Interview on 03/16/16 at 10:23 am with the Resident Care Coordinator revealed: -Medication Aides should have contacted Resident #3's mental health Practitioner in January 2016 of the incidents on the 10th and 21st. -If staff did not document they notified the mental health provider, then chances are the provider was not notified. Interview on 03/16/16 at 4:28 pm with a second shift Medication Aide (MA), revealed: -On 01/10/16 she worked first shift, when she came on duty the third shift MA reported to her that Resident #3 got into it with another resident. -Resident #3 had been agitated all night. -The incident was not reported to the RCC or the Operations Manager -On 01/21/16 at 4:33 pm when Resident #3 returned he acted like he was under the influence, so she contacted the medical provider (Nurse Practitioner) about holding the resident's medications because he had been drinking. -The Medical provider said hold until 8:00 am the next morning. -She did not think to contact the Mental Health provider.	{D 273}		

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{D 273}	Continued From page 71 Interview on 03/16/16 at 10:34 am with the Operations Manager revealed: -When a Medication Aide obtained verbal orders from a Medical Practitioner regarding a resident's behaviors, then the Mental Health practitioner should also be notified. Interview on 03/07/16 at 11:25 am with Resident #3's girlfriend revealed: -She often got into fights with Resident #3, she was afraid of him, because he gets angry. -Over the weekend she was moved to another room because Resident #3 called her names. He yelled, screamed and threw chairs. -Some of it made her mad enough to leave, so she ran away from the facility on Saturday and Sunday (March 5 and 6, 2016). -Resident #3 was "violent" to her today, so facility staff told her to come into the med-room until he calmed down. -On many occasions she had seen Resident #3 bring "weed" into the facility. -On Saturday, March 5, 2016, Resident #3 had hit her on the shoulder and smacked her hand. On the same date Resident #3 was upset with her and he slung a brush and hit her with the brush. -Facility staff checked on her every 2 hours in the middle of the night. Interview on 03/07/16 at 3:15 pm with Resident #3 revealed: -He had lived at the facility for 5 months. -He had not touched anyone at the facility, except his girlfriend (a resident at the facility). -It was common for residents to bring "weed," (Marijuana) to the facility, it sells for a nickel or dime, and facility staff were aware. -He and his girlfriend had been caught by staff smoking "weed", and was told if they get caught again they will have to leave the facility (unable to	{D 273}		

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{D 273}	Continued From page 72 recall when). Confidential interview with another resident revealed: -Recently, she moved into the room with Resident #3's girlfriend and she did not want to be roommates with Resident #3's girlfriend; because Resident #3 gets violent and was trouble. Confidential interviews with two residents revealed: -On Sunday, March 6, 2016, they observed Resident #3 threw a brush and hit his girlfriend. -Resident #3's girlfriend kept asking him for a cigarette, and Resident #3 told her to leave him alone, she would not so he threw the brush and hit her. Interview on 03/07/16 at 4:30 pm with a Personal Care Aide (PCA) revealed: -Resident #3 and his girlfriend were always yelling and arguing. -Residents and staff were afraid of Resident #3 because he yelled and threw things. Interview on 03/15/16 at 2:53 pm with the housekeeper revealed: -On 03/12/16 Resident #3 came back to the facility drunk and "high." -She could tell that he was drunk because his speech was slurred. -She was aware the resident was high because he was loud, yelling, cursing residents and staff. Review of Resident #3's record revealed no drug screens in the resident's record. Interview on 03/10/16 at 2:33 pm with the Medical Nurse Practitioner (MNP) revealed: - "Most people at the facility was on controlled	{D 273}		

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{D 273}	Continued From page 73	{D 273}		

drugs" and had orders to be tested when staff suspected drug use.
-If Resident #3 had behaviors of drug use, then he should have been tested.
-Resident #3 had narcotic pain medications and often asked for those medications.
-Resident #3 had history of drug use, it was suspected the resident was possibly "cheeking," his medications by holding the medication in his cheeks to spit out, and try to sell to someone else.
-If the resident spit out the crushed medications quickly enough he can salvage enough of the actual medication to resale.
-Staff told, but he did not validate and on 03/07/16 he gave the facility an order for Resident #3 to sit in the medication room for 15 minutes after consuming his narcotic medications.
-He was certain after 15 minutes the medication was dissolved and could not be resell.
-This was done to ensure the resident did not take the medication out of his mouth and was unable to resale.
-In the past he had discussed with the resident about not doing drugs (Unable to recall specific dates).
-No one at the facility had reported to him the resident going out of the facility and possibly involved in drugs.
-The resident had history of drug use, and he had current reports of the resident returning to the facility intoxicated.

B. Review of Resident #19's current FL2 dated 08/04/15 revealed:
-Diagnoses included paranoid schizophrenia, personality disorder; and antisocial traits.

Review of Resident #19's Resident Register revealed the resident was admitted to the facility

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{D 273}	Continued From page 74 on 09/04/12. Review of Resident #19's record revealed: -The court appointed the resident a legal guardian on 09/10/01. Review of Resident #19's Care Plan completed by the RCC and signed by the resident's physician on 05/12/15 revealed: -The resident needed supervision with eating, does not document the type of supervision needed. -Resident #19 sometimes had delusions that he was a psychiatrist and owned the facility. -He asked for his as needed medications when needed. Review of Resident #19's record revealed: -A lab report dated 12/23/15 with a "reactive" communicable disease antibody. Interview on 03/14/16 at 10:30 am with the laboratory company that assessed Resident #19's lab results revealed: -Resident #19 had a communicable disease and precautions should be taken with anyone that had contact with the resident to ensure no blood contact. -She can't say what specific precautions to use because she does not know Resident #19's habits or activities, but any precaution to avoid possible blood contact should be taken by the facility. Interview on 03/14/16 at 10:37 am and at 1:56 pm with nurse from local County Health Department revealed: -Communicable disease, like that of Resident #19 was reportable only if the individual was symptomatic.	{D 273}		

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{D 273}	Continued From page 75 -She recalled talking with the facility previously regarding the protocol to follow when someone was diagnosed with communicable disease. -Precaution should be taken to avoid potential blood exposure when having sex. -The facility should have some type of policy in place to address sexual behaviors of residents diagnosed with this type of communicable disease, because sexual behaviors was a common happening with mental health residents. Interview on 03/09/16 at 3:12 pm with Resident #19 Revealed: -He lived at the facility for almost 2 years. -He had intercourse with Resident #9. -It's been "awhile" since he had intercourse with Resident #9, at least a month. -He did not use protection (condom) when he had intercourse with Resident #9. -He did not feel there was a need to use protection "I don't need it." -He was aware that Resident #9 had sexual relations with other male residents, but he did not care about that. -He was unaware if the facility provided education regarding using protections when engaging in sexual activity. -He had sex with Resident #9 at least 2-3 times, all sexual activity was in his room when the roommate was out of the room. Interview on 03/15/16 at 3:50 pm with Resident 19's former roommate revealed: -He walked in the room on two occasions in January 2016, and one occasion in mid-February 2016, and observed Resident #19 and #9 engaged in sexual activity; so he left the room until they had finished. Interview on 03/14/16 at 11:12 am with Resident	{D 273}		

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{D 273}	Continued From page 76 #19's guardian revealed: -She was not aware of the resident's sexual activity. -She could not recall the facility notifying her they tested the resident for a communicable disease, or that the resident tested positive for a communicable disease. -She had been Resident #19's guardian since July 2001, and was unaware if the resident had a communicable disease prior to being admitted to the facility. -She would like the documents forwarded to her related to positive test of communicable disease and she would want to know about the resident's sexual activity. Interview on 03/15/16 at 2:56 pm with the transportation driver/housekeeper revealed: -Last week, she took Resident #19 to the doctor's office. -When the nurse asked Resident #19 if he had blood transfusion or sex with anyone lately, she heard Resident #19 tell the nurse that he had sex with Resident #9. -Resident #19 stated he did not have sex with anyone else, only Resident #9. -Prior to hearing Resident #19 say he had sex with Resident #9 she was unaware that Resident #19 was sexually active with Resident #9. -She did not share this information with management or any staff at the facility. Interview on 03//11/16 at 11:50 am with Resident #9 revealed: -She did not have sexual relations with anyone at the facility. -She had never had sex with anyone at the facility. -She did have condoms in the drawer in her room, but did not use them.	{D 273}		

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{D 273}	Continued From page 77 Interview on 03/09/16 at 3:30 pm and 03/11/16 at 3:06 pm with the second shift Personal Care Aide (PCA) revealed: -Two weeks ago (February 2016) she saw Resident #9 and #19 engaged sexual activity. -She broke it up, and had Resident #9 to leave the room. -She did not tell anyone because Resident #9's guardian said it was okay for her to have sex. -She had not seen the resident in any sexual activity since. Interview on 03/11/16 at 3:12 pm and 3:35 pm with the RCC revealed: -She was unaware that Resident #19 had been engaged in sexual activity with Resident #9 two weeks ago. -Although staff were not aware Resident #19 had a communicable disease, they still should have reported the incident to her. C. Review of Resident #2's current FL2 dated 12/16/15 revealed diagnoses that included polysubstance dependence. Review of Resident #2's record revealed: -Another FL2 dated 02/18/16 included diagnoses seizures, mood disorder, post-traumatic stress disorder. -Resident #2 had a guardian. -Resident #2 was on probation. Review of Resident #2's record revealed: -A physician signed standing order dated 03/20/15 which included the following: -1. Urine Drug Screen (UDS) monthly for all residents on controlled substances. -2. UDS on any resident who has abnormal behaviors or if seen abusing medication or illegal	{D 273}		

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{D 273}	Continued From page 78 drugs/substances. -3. UDS may be obtained after home visits if residents displays abnormal behaviors. Review of the facility charting notes dated 03/06/16 at 10:50 pm for Resident #2 revealed: -Resident #2 had increase behavior issues throughout the weekend. -Resident #2 walked away from the facility around 6:40 pm into the woods and refused to return back to the facility. -Mobile crisis was called. -Resident #2 returned to the facility on her own around 7:00 pm. -Resident #2 refused Emergency Room (ER) visit for Involuntary Commitment (IVC) which had been discussed previously. -Documentation Resident #2 was on 15 minute checks. -At 7:30 pm Resident #2 was not in the facility. -Staff found Resident #2 at a church near the facility and Resident #2 stated "She was going to meet someone and get drugs." -Documentation the guardian was called. -Resident #2 returned back to the facility at 8:15 pm on her own. Review on 03/07/16 of the local county communication Emergency Medical Services (EMS) 911 report dated 03/06/16 at 5:49 pm revealed: -Facility called and reported the following: -Resident #2 had chest pain, was alert and oriented, was breathing normal, was changing color and was red, was not clammy. -Resident #2 had not had a heart attack of angina (heart pains) in the past. -Resident #2 had taken a drug in the past 12 hours "Got in the car with a man and he gave her white powder."	{D 273}		

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{D 273}	Continued From page 79 -Facility called back at 6:06 pm stating Resident #2 had walked away from the facility again, before EMS had arrived. -Documentation on 03/06/16 at 6:43 pm Resident #2 was left in the facility care and the facility would transport Resident #2 to the Emergency Room (ER). Review of the facility incident report dated 03/06/16 for Resident #2 revealed: -The incident report was completed at 6:40 pm and signed by the Supervisor-In-charge (SIC). -Resident #2 walked off from the facility property 3 times on 03/06/16. -Mobile crisis and on-call guardian was notified. -No documentation the physician was notified. -No documentation a UDS was completed. Interview on 03/07/16 at 4:00 pm and on 03/11/16 at 11:30 am with the Resident Care Coordinator (RCC) revealed: -She had been employed at the facility for 5 years. -She was responsible for overseeing the care staff which included Medication Aides (MA) and the Personal Care Aides (PCA). -She was aware Resident #2 had increase behavior issues over the weekend. -The RCC worked on 03/06/16 when Resident #2 "walked off around 5:45 pm." -Resident #2 had walked away from the facility three times on 03/06/16. -The RCC went to the facility parking lot, staff informed her Resident #2 had walked away from the facility toward the church. -She told the staff to "get in the car and go find her." -Resident #2 returned to the facility and told me she had gotten into a car with a man and snorted a white powder.	{D 273}		

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{D 273}	Continued From page 80 -She called Emergency Medical Service (EMS) because Resident #2 complained of chest pain. -She called the local sheriff's department also. -She called the guardian and he told her to send Resident #2 to the ER. -Resident #2 walked away from the facility again after complaining of chest pain before EMS had arrived. -EMS returned Resident #2 to the facility and "checked her out." -Resident #2 told EMS and the sheriff's deputy she had snorted a "goody powder." -The RCC had assumed Resident #2 was ok since EMS had cleared her. -Resident #2 refused to go with EMS to the ER for evaluation. -She was aware Resident #2 had a standing order for UDS but thought it was an old order since it was almost a year old. -She thought the Nurse Practitioner had discontinued the order for the UDS for Resident #2. -The staff probably just overlooked the order for the UDS for Resident #2. -The RCC did not obtain an UDS for Resident #2. Telephone interview on 03/09/16 at 11:05 am with Resident #2's probation officer revealed: -Resident had been on court ordered probation since December 2015 for assaulting another resident in the facility. -Resident #2 had a UDS completed in his office on 01/04/16 and tested positive for methamphetamine. -He was made aware on 03/08/16 Resident #2 had left the facility three times, gotten in a car with a man, and snorted a white powder which had occurred on 03/06/16. Interview on 03/07/16 at 5:00 pm and on 03/10/16	{D 273}		

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{D 273}	Continued From page 81 at 10:00 am with the facility Operations Manger (OM) revealed: -She was aware Resident #2 left the facility on 03/06/16, but was not familiar with every detail. -She was aware Resident #2 had a positive UDS for methamphetamine about a month ago. -She was aware Resident #2 had left the facility property on 03/06/16 and gotten into a car with a man, but was not aware Resident #2 told staff she snorted a white powder. -If Resident #2 said she had done drugs the staff could call for a UDS, if Resident #2 had no behaviors a UDS could be obtained with the next lab draw. Telephone interview on 03/10/16 at 2:30 pm with Resident #2's Medical Provider revealed: -He was unaware Resident #2 had "snorted the white powder" on 03/06/16. -He had written the standing order for the UDS testing on 03/20/15, and expected it to be followed. -The standing order was good for 1 year after it had been written. -"I definitely wanted the order followed with Resident #2, there is too much of a problem in the facility." -He was aware Resident #2 had a UDS completed on 01/04/16 and tested positive for methamphetamine. -If Resident #2 had refused the urine drug screen, it should be documented. -He relied on the facility to follow his orders as written. Telephone interview on 03/08/16 at 11:30 am with Resident #2's guardian revealed: -He was Resident #2's appointed guardian for over one year.	{D 273}		

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{D 273}	Continued From page 82 -He was unaware Resident #2 had gotten in a car with a man on 03/06/16, but the facility did inform him Resident #2 snorted the white powder. -He was aware Resident #2 had a UDS completed on 01/04/16 and tested positive for methamphetamine. -He expected the facility to obtained a UDS on Resident #2 after she had snorted the white powder on 03/06/16. Interview on 03/07/16 at 12:45 pm with Resident #2 revealed: -She walked away from the facility when she got mad. -She did not sign out when she left the facility. -She is aware she is not to leave the facility. -She is aware she is on probation. -She left the facility walking on 03/06/16 to get drugs. -She had gotten in the car with a man (I know him) and did drugs, she stated "I am a crack head." -She did not want to go the ER on 03/06/16 with the EMS. Interview on 03/07/16 at 4:30 pm with a second shift PCA revealed: -She had worked on 03/06/16. -She was aware Resident #2 left the facility on 03/06/16. -Resident #2 said she had gotten in a car with a man and snorted a white powder. -The PCA did not think Resident #2 had snorted any drug, "She does things for attention." _____ The facility failed to notify Resident #3's mental health provider of the resident's verbal and physical aggressive behaviors, with alcohol and suspected illegal drug consumption and was	{D 273}		

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{D 273}	Continued From page 83 detrimental to the health and safety of Resident #3 and his girlfriend (a resident at the facility); failure to notify the medical provider or obtain a urine drug screen regarding Resident #2's incident on 03/06/16 "snorted white powder"; and ensuring safe sexual behaviors were practiced by Resident #19. The facility did not provide an acceptable Plan of Protection for residents nor a date by which this violation shall be corrected A Directed Plan of Protection was issued to the facility on 3/18/16. THE DATE OF CORRECTION FOR THIS UNABATED B VIOLATION SHALL NOT EXCEED April 18, 2016.	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to implement orders for blood pressure checks twice weekly for 1 of 9 sampled residents (Resident #3). The findings are:	D 276		

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D 276	Continued From page 84 Review of Resident #3's current FL2 dated 09/17/15 revealed: -Diagnoses included hypertension. -Orders for blood pressure every hour. -Medication orders for Norvasc 10mg once daily (used to treat high blood pressure); Clonidine 01. mg twice daily (used to treat high blood pressure); and Hydrochlorothiazide 25mg once daily (used to treat high blood pressure). Review of Resident #3's record revealed an order dated 10/06/15 that increased the resident's Clonidine 0.1mg to 0.2mg twice daily, with orders to check the resident's blood pressure twice weekly. Review of Resident #3's December 2015, January, February, and March 2016 electronic Medication Administration Records (eMARs) revealed: -No blood pressures were documented on the MARs. Review of Resident #3's record revealed no documented blood pressures. Interview on 03/10/16 at 2:36 pm with the medical Nurse Practitioner (NP) revealed: -When Resident #3 was in the office in October 2015, the resident's blood pressure was high at 160/100. -There was request for blood pressures to be recorded twice weekly. -The resident's Clonidine 0.1mg twice daily was increased to 0.2 mg twice daily. -The resident was in the office in November 2015, and was seen by another NP, the resident's blood pressure documented was 134/84. -He searched the resident's record from October 2015 through today's date 03/10/16, there was no	D 276		

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D 276	Continued From page 85	D 276		

documentation from the facility related to Resident #3's blood pressures, furthermore there was no documentation from the facility they tried to obtain the blood pressure and the resident refused.

Interview on 03/10/16 at 10:41 am with the pharmacist revealed:
-They received an order on 10/06/16 to increase the Clonidine to 0.2mg twice daily, and the order was changed on Resident #3's eMARs.
-They did not put the order to obtain the resident's blood pressures twice weekly on the MARs because those orders were considered "ancillary orders", and were to be entered by facility staff.
-If the facility staff was confused about what to do with the order they should have contacted the pharmacy right away to be on the safe side.

Interview on 03/10/16 at 3:45 pm with the second shift Medication Aide (MA) revealed:
-She checked Resident #3's eMARs from October 2015 through March 2016, and there was no documentation of blood pressure recorded.
-There was no documentation that staff attempted to obtain a blood pressure and Resident #3 refused.
-The MAs were responsible for obtaining a resident's blood pressure, if the resident refused to let staff obtain a blood pressure that would be documented on the eMARs and in the resident's record.
-Just now, she searched Resident #3's record and found no documented blood pressures or documentation the resident refused to let staff obtain his blood pressure.
-The order written by the nurse practitioner visiting the facility on 10/06/15, was given to the first shift MA working the medication cart where

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D 276	Continued From page 86 Resident #3's medications stored. -The MA was to put the order for the blood pressures twice weekly in the computer (eMARs) and fax the written order to the pharmacy. -The order was then given to the Resident Care Coordinator (RCC) to check behind the MA and ensure it was entered correctly. Interview on 03/10/16 at 4:15 pm with the RCC revealed: The pharmacy was supposed to put the blood pressure on Resident #3's MAR. -She checked through her papers and found where she observed Resident #3's blood pressures were not on the MARs, so she faxed the order again to the pharmacy. -She does not have a fax confirmation to show the date she faxed the order again to the pharmacy, and she did not recall when she faxed the order to the pharmacy. -She must have gotten busy and forgot about Resident #3's order for blood pressure twice weekly, so the order did not get put on the MARs. Resident #3 refused an interview on 03/10/16, 03/11/16, and 03/15/16, also the MAs revealed Resident #3 refused to allow them to obtain his blood pressure on 03/10/16 through 03/12/16.	D 276		
{D 287}	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an	{D 287}		

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{D 287}	Continued From page 87 individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide forks and knives as necessary for meals for residents to consume their meals. The findings are: Based on observations, interviews and record review, the facility failed to treat residents with respect, consideration, dignity, and full recognition of his or her individuality by failing to provide forks and knives as appropriate for meals resulting in residents being unable to cut up their food (including meat), residents having to eat with their hands and residents not having the necessary eating utensils for consumption of some foods such as spaghetti. [Refer to Tag 911 G. S. 131D-21(1) Residents Rights (Type B Violation)]	{D 287}		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance	{D 338}		

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{D 338}	Continued From page 88 continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to protect residents from neglect and exploitation by failing to protect residents (#2 and #14) from illegal drug use in the facility and by implementing a resident "activity work program" that was used as a tool for discipline and behavior management which residents were not given fair or equitable compensation for work completed that benefited the facility. The findings are: A. Review of Resident #14's current FL2 dated 01/12/16 revealed: -Diagnoses which included schizophrenia and polysubstance abuse. Review of Resident #14's record revealed a physican order dated 11/03/15 to contact the guardian and recommended to not allow Resident #14 to leave the facility due to his alcohol intoxication over the weekend, and to reconsider allowing Resident #14 to sign himself out of the facility. Review of Resident #14's record revealed: -A letter dated 11/06/15 from Resident #14's guardian stating he was not to leave the facility due to his history, "purchase and consume alcohol until drunk" unless with a staff member or another responsible adult. Review of Resident #14's record revealed he had tested positive for marijuana in August 2015, and had gone to the Emergency Room (ER) with a	{D 338}		

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{D 338}	Continued From page 89 blood alcohol level of 197 "high" (reference range 0-10 per laboratory at the local hospital) in October 2015, both incidents while living in the facility. Review of Resident #14's hospital discharge summary dated 01/13/16 revealed: -He was "found to be confused" by the facility staff and brought to the ER on 01/11/16. -He was admitted to the hospital on 01/11/16. -The health and physical documented the chief complaint as altered mental status, acute renal failure, and hyponatremia. -Diagnoses on discharge included urinary tract infection, mild metabolic encephalopathy, dehydration, positive blood culture, acute kidney injury pre-renal, hypernatremia possible chronic, schizophrenia, possible hyperthyroidism subclinical. -His Urine Drug Screen (UDS) was positive for methamphetamine and marijuana. -Resident #14 was discharged on 01/13/16 back to the facility. Review of Resident #14's record revealed: -Resident #14 had a legal guardian. -Resident #14 had a signed physician standing order dated 03/20/16 for random Urine Drug Screen (UDS) for any abnormal behaviors or seen abusing medications or illegal drugs/substances. Review of the facility charting notes for Resident #14 revealed: -On 03/12/16 Resident #14 had abnormal behaviors, drowsy with increase sleep habits the past 2 days. -On 01/29/16 Resident #14 was upset with another resident and got into a verbal altercation. -On 01/26/16 Resident #14 was involved in an	{D 338}		

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{D 338}	Continued From page 90 altercation with another male resident. Interview on 03/09/16 at 4:10 pm with Resident #14 was unsuccessful. Telephone interview on 03/18/16 at 9:00 am with Resident #14's legal guardian revealed: -He had seen Resident #14 about a week ago in the facility, and Resident #14 appeared to be doing better. -He was aware Resident #14 tested positive for methamphetamine and marijuana in January 2016, but was unsure where Resident #14 had gotten the illegal drugs. -He was aware family members visited Resident #14 at the facility. -The family members called and informed him prior to visiting Resident #14 at the facility. -On several conversations with family members he discussed and educated them on Resident #14's drug habits and alcohol abuse. -The family had taken Resident #14 out of the facility for overnight visits, but had stopped due to Resident #14 "could get his hands on anything with alcohol." -He informed family members they are responsible for Resident #14 when they take him for overnight visits and when they visit him in the facility. -"Resident #14 will drink anything with alcohol even mouthwash." -He was aware of a drug house near the facility, but Resident #14 cannot leave the facility without a staff person. -The facility did not have enough staff to do 1 on 1 care with the residents, but he had seen staff in the building when he visited Resident #14. -He was not sure if drugs were in the facility, but "every facility has the potential for drugs to be brought in."	{D 338}		

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{D 338}	Continued From page 91 -He did not think Resident #14 brought drugs into the facility because Resident #14 "Is a drug user not a distributor." -Resident #14 had a "life history" of substance abuse. Interview on 03/07/16 at 8:30 am with a resident revealed, "It is easier to get pot here than a beer." Interview on 03/07/16 at 11:28 am with a second resident revealed: -He used to smoke marijuana. -Facility staff were aware of residents that smoked marijuana. -Small amounts of Marijuana comes into the facility and it sells for $2.00. -It's enough to get a "Buzz," it's only a "tiny amount." -Only a few people do it, nobody gets hurt. Confidential interview on 03/09/16 at 3:30 pm with a staff member revealed: -She is aware of illegal drugs in the facility. -Several of the residents have tested positive in the past few months. -Residents bring drugs into the facility. -We were told by management we cannot search the residents, only their rooms. -She told the Resident Care Coordinator and the Operation Manager about residents bringing drugs into the facility. -"Sometimes I don't feel safe." -"The owner never comes to the facility." Interview on 03/10/16 at 8:30 am with a third resident revealed: -Resident #14 had a family member who brought marijuana into the facility. -Resident #14 sells a "joint" for five dollars.	{D 338}		

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{D 338}	Continued From page 92 Interview on 03/10/16 at 9:50 am with a Medication Aide (MA) revealed: -We do not require family or friends to sign in when they visit residents in the facility. -We do require the residents to sign out if they leave with family or friends. -We require the family or friend to sign the resident out if they take them out of the facility. Interview on 03/16/16 at 2:30 pm with another MA revealed: -She is aware there is "pot" in the facility and had caught Resident #14 in December 2015 smoking a "joint" outside on the facility grounds. -She had taken the "joint" away from Resident #14 and had given the "joint" to the Resident Care Coordinator (RCC). -When the nurse comes to collect laboratory on residents they refused because they think they might be tested for drugs. -The facility RCC and the Operation Manager (OM) are aware drugs and alcohol are in the facility. Interview on 03/11/16 at 11:30 am and on 03/16/16 at 2:45 pm with the RCC revealed: -Staff told her there might be drugs in the facility, but there was no proof. -Staff can search a resident's room, but not the resident. -A staff member brought a small bag of marijuana they had found in the facility to her about 2 years ago, and she flushed it down toilet. -"We flushed in the toilet a lot of what the staff said is pot." -She denied staff bringing any drug substance they had found in the facility to her in the past 3 months to destroy. Confidential interviews with 6 residents revealed:	{D 338}		

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{D 338}	Continued From page 93 -One resident heard of drugs in the facility, but does not see it. -About six months ago Resident #14 and another resident were drunk and falling all over the place, throwing up in the trash can. -Two residents said some residents smoked "pot," but went to the far end of the porch, so they were not seen by staff. -Two more residents said some resident's smoked "weed," on the back porch. -Two residents revealed a resident drank perfume and mouth wash for alcohol to get high, and he also bought pain pills from other residents to take. -One resident said last month (February 2016) after "payout," the same and the next day he saw other residents smoking "pot." -It was common after payout to see residents smoking pot. -Another resident at the facility got the pot and bought it back to the facility. Review of Resident #14's record revealed: -A urinalysis was collected on 01/27/16 but not a UDS. -No laboratory result were noted for UDS since the positive testing on 01/11/2016. B. Review of Resident #2's current FL2 dated 12/16/15 revealed: -Diagnoses included polysubstance dependence and post-traumatic stress disorder. -Disoriented documented constantly and intermittently. -Inappropriate behaviors documented, wanderer, verbally abuse, injurious to self, injurious to others, and injurious to property. Review of Resident #2's record revealed Resident #2 had a legal guardian.	{D 338}		

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{D 338}	Continued From page 94 Further review of Resident #2's record revealed: -A physician signed standing order dated 03/20/15 which included the following: -1. Urine Drug Screen (UDS) monthly for all residents on controlled substances. -2. UDS on any resident who has abnormal behaviors or if seen abusing medication or illegal drugs/substances. -3. UDS may be obtained after home visits if residents displays abnormal behaviors. Review of the facility charting notes dated 03/06/16 at 10:50 pm for Resident #2 revealed: -Resident #2 had increased behavior issues throughout the weekend. -At 7:30 pm Resident #2 was not in the facility. -Staff found Resident #2 at a church near the facility and Resident #2 stated, "She was going to meet someone and get drugs." -Resident #2 returned to the facility at 8:15 pm on her own. Telephone interview on 03/10/16 at 2:30 pm with Resident #2's Medical Provider revealed: -Resident #2 had a physican standing order dated 03/20/15 for a Urine Drug Screen (UDS). -"I definitely wanted the order followed with Resident #2, there is too much of a problem with drugs in the facility." -He was aware Resident #2 had a UDS completed on 01/04/16 and tested positive for methamphetamines. Telephone interview on 03/08/16 at 11:30 am with Resident #2's guardian revealed: -He informed Resident #2 of the dangers in the community with drug use several times. -Facility staff contacted him multiple times in regards to Resident #2 saying she had left the	{D 338}		

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{D 338}	Continued From page 95 facility to get drugs. -He was aware Resident #2 had a UDS on 01/04/16 and tested positive for methamphetamines. -Resident #2's money is very limited, "I am not sure how she is getting drugs." Telephone interview on 03/08/16 at 2:30 pm with the local narcotic detective revealed: -He was aware of 2 drug houses near the facility and had spoken to the facility registered nurse about this concern. -There was methamphetamine activity at the drug houses. -There was a murder investigation the summer of 2015 at one of the drug house's related to methamphetamine activity. Telephone interview on 03/09/16 at 11:05 am with Resident #2's probation officer revealed: -Resident had been on probation since December 2015. -Resident #2 had a UDS completed in his office on 01/04/16 and tested positive for methamphetamine. Interview on 03/07/16 at 11:25 pm and at 12:45 pm with Resident #2 revealed: -She walked away from the facility when she had gotten mad. -She was aware she is not to leave the facility. -She was aware she is on probation. -She left the facility walking on 03/06/16 to get drugs. -She had gotten in the car with a man (I know him) and did drugs. -She said her boyfriend bought "weed" into the facility. -She stated, "I am a crack head."	{D 338}		

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{D 338}	Continued From page 96 Interview on 03/07/16 at 5:00 pm and on 03/11/16 at 11:15 am with the facility Operations Manger (OM) revealed: -She was aware Resident #2 while living at the facility had a positive UDS for methamphetamine about a month ago. -If Resident #2 said she had done drugs the staff could call for a UDS, if Resident #2 had no behaviors a UDS could be obtained with the next lab draw. Interview on 03/14/16 at 4:45 pm with second shift Personal Care Aide (PCA) revealed: -He was aware residents were using illegal drugs in the facility. -He smelled marijuana on the facility grounds, but had not seen who had been smoking the marijuana. -He had informed the Supervisor which was his chain of command. -He was unaware how the drugs are getting into the facility, or who was bring the drugs in. Interview on 03/11/16 at 11:15 am with the facility OM revealed: -Facility does not have a substance abuse policy, "Only that they don't allow it." -In the past residents have brought drugs into the facility, but she is unaware of any residents who bring drugs into the facility now. -She is familiar with the drug house"blue trailer" location, but had not seen facility residents going to it. -The staff can search a resident's room but not the resident. -She cannot recall the last time a resident's room was searched, but staff does not need her permission to do a resident room search. -She does not recall any recent incident reports of drugs in the facility.	{D 338}		

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{D 338}	Continued From page 97 C. Interviews with residents revealed that some residents "work" at the facility. Review of the facility's General Policies found in the admissions packet and the Activity Work Program (AWP) - Agreement to Participate form revealed the AWP is a part of Cedarbrook Residential Center's activity program. Any resident of Cedarbrook may choose to participate. Our objective of this program is to help all residents become involved with our community. Please review an outline of our AWP program and decide if you wish to participate. If you choose to participate you may do so, and choose not to participate at any time in the future. AWP is an activity which is totally voluntary. No residents are required to perform any work related assignments by oral or written agreement while residing at Cedarbrook Residential Facility. Any work-related therapy task will be done on a volunteer basis or as requested by attending physician for work-related therapy or as a divisional act. Review of the current AWP resident duty roster revealed: -36 residents were listed as participating. -Duties included: end 400 smoking area cleanup, linens, wipe rails, windows kitchen, breakfast trash, nightly cleaning, trash, trash and rails 200, floors, dayroom smoking area, railings his hall (hall resident lived on), 200 dayroom wipe down, basketball area, store assistant, med dayroom furniture, dining room setup, Wednesday box/trash, 100 dayroom, dinner trash, act clean up, Pepsi guy, make copies, PM activities, activities assistant, messenger, store cart, room clean, keep it up, good behavior (2 residents).	{D 338}		

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{D 338}	Continued From page 98 Random interviews with 18 residents regarding the AWP store credit revealed: -One indicated they would do the work whether there was store credit or not. -One stated the compensation was "alright, they were not trying to make money". -One stated she would rather be given cash so she could by other items at the local shopping center. -One said he would prefer cash so he could purchase better cigarettes than what were available at the store. -One said the work should only take about fifteen minutes to complete so the pay was fair. -Eighteen residents stated they volunteered or asked staff if they wanted to participate in the AWP. -Six residents indicated they thought the $5.00 was fair compensation. -Of the twelve remaining residents, they thought fair compensation would be: One stated $18-20 per week. Three indicated $10 per week. One wanted $15 per week. One stated $2-3 per hour. One indicated minimum wage ($7.25 per hour) would be fair since the activities are similar to jobs in the community. "One hour minimum wage is more than $5.00 per week." One stated $10 or $20 per week. One resident wanted to work two jobs to earn $10. Random interviews with seven residents regarding the AWP store credits revealed: -Two residents stated store credits are not taken away. If a resident had a "bad day" staff might tell them to go take a rest, lay down. Store credit was not earned because residents were told not to do their activity that day.	{D 338}		

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{D 338}	Continued From page 99 -One stated "bad behavior can result in being docked store credit, usually never more than $2.00". -One stated if he did not do his activity he did not receive store credit. You could lose store credit for placing a chair in the hallway and sitting in it. Last time he lost store credit was about 3-4 months ago. -One said you lose store credit if you are caught smoking in your room, for different behavioral issues or not doing your chores. -Another resident stated "they could lose" store credit for many things, like cheeking medications, acting out or cursing. -One indicated a resident would have "their hours cut" but would not lose store credit. This was the new (AWP) policy but it "still had the same effect" (as losing store credit). Interview on 3/15/16 at 2:10 pm with a housekeeping staff revealed if there was not the AWP program housekeeping would do the work. She would "go behind" a resident and check or "redo" the task. Over time she had gained knowledge of the residents who did a good job completing their task and the ones to go check on after they were done. There was no AWP on the weekend and she worked weekends, so she did all the housekeeping tasks. Interview on 3/15/16 at 2:20 pm with another housekeeping staff revealed he was a new employee, had some knowledge of the AWP program and indicated he and the other housekeeping staff would do the work if there was not an AWP program. Interview on 3/15/16 at 2:30 pm with a third housekeeping staff revealed housekeeping staff do the cleaning regardless of the AWP program.	{D 338}		

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{D 338}	Continued From page 100 Housekeepers made sure the facility was clean. Interview on 3/10/16 at 3:00 pm and 3/16/16 at 5:05 pm with the Activities Director (AD) revealed: -She started as AD in January. Prior to January she had worked in the kitchen. -Prior to January department supervisors were assigned residents who participated in the AWP. The AD was now responsible for the AWP. -There was a new form used by the residents that tracked their AWP work. Any staff person could sign-off on the form if they observed the resident doing their AWP work. -When talking with residents she stressed it was a voluntary program. It was an opportunity to improve where they (the residents) lived, physical improvements or there were some residents who supported staff (ex. made copies). -When a resident was interested in participating in the AWP, she would meet with the resident, discussed their interests, what they would like to do, interest level in the activity, and come up with a matching activity. -She planned to start using the new "Activity Work Program (AWP) - Agreement to Participate" form the AOM recently created. (AOM provided copy on 3/16/16 after it had been approved by the Administrator). -Staff would now report behavioral issues to her. Based on the behavioral issues, it would determine how many days the resident would be allowed to participate in the program the following week. Residents were not docked store credit for what they had already earned. They would work one less day the following day or the following week. -Usually one day was "docked" per incident. If it was a more serious behavior, such as fighting, then the resident would be docked two days. -She has had no communication or program	{D 338}		

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{D 338}	Continued From page 101	{D 338}		

coordination with a resident's mental health provider as related to the resident's participation in the AWP.
-Cash was not an option in lieu of store credit. It would be a concern having cash available at the facility due to the potential of increasing residents stealing behaviors.

Review of AWP Time Sheet form revealed it documented:
-Resident's name.
-Date for the week.
-Activity details.
-Activity time frame.
-Number of days eligible for participation.
-Time of participation.
-Days of week listed Wednesday-Tuesday.
-Staff signature.

Review of the "Activity Work Program (AWP) - Agreement to Participate" form revealed:
-A description of the program.
1) AWP is a voluntary activity and is not employment. AWP is not a job.
2) As with all activities you can choose to participate or not participate on a daily basis.
3) If you choose to participate and follow the participation guidelines, you will receive a credit in the Activity store for each day you participate, with a limit of five dollars of credit per week.
4) The AWP credit will be available at the Activity store weekly.
5) The type of individual activity performed will be determined by the resident with help from the Activity Director.
6) As with any other activity, this activity will be specific in content and have a time frame for participation.
7) Any staff who observe a resident participating in their AWP activity during their time frame may

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{D 338}	Continued From page 102 sign their AWP participation form. 8) Store credits will be awarded based on the number of signatures, with a maximum of one per day and five per week. 9) As with all activities, residents who have difficulty participating in an activity without disruptive behavior may not be allowed to participate in this activity. Residents who are disruptive to other residents or staff may become either ineligible to participate in this activity or eligible for only limited participation. 10) The level of available participation will be determined weekly by the Activity Director and/or management. The AWP may be canceled at any time at the facility ' s discretion. -Place for resident signature -Place for Activity Director's signature. Review of a letter from a local Psychiatrist hired by the facility to review and report on the Activity Work Program revealed: -Letter dated and signed 2/26/16. -"In summary, in my opinion this program meets several important needs of the residents of Cedarbrook as well as the community as a whole. I don't find any circumstances of residents being unfairly treated, taken advantage of or coerced into participation." Interview on 3/11/16 at 11:15 am, 3/15/16 at 3:47 pm and 3/16/16 at 2:30 pm with the Assistant Operations Manager (AOM) revealed: -He supervised the AD, who was also his spouse. -He emphasized the AWP was a voluntary program. -The program changed from residents reporting to a department head to using a form where staff documented a resident's participation in the AWP. -Residents do not lose store credit. If a resident was disruptive, the resident would be asked not	{D 338}		

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{D 338}	Continued From page 103 to participate in the AWP. It was more important to have the resident address and resolve their disruptive behavior. Resident would determine when they were "able" to participate, more responsibility was placed on the resident for their behavior. -This was similar to a resident acting out during an activity, they would not receive a prize for that activity. -The AWP was never intended to be judgmental of a resident's behavior and lose store credit. He and the AD were trying to remove this perception of the program out of the culture at the facility. -A resident could earn up to $5.00 per week regardless of the number of days worked in a week. -When a resident was disruptive they would limit the resident's participation in the AWP, usually one day. -If a resident failed a drug test, the resident would miss five days. There was only one time this had happened and that resident is no longer at the facility. -Participation was not always limited if a resident was just having a "bad day". Limiting participation was at the discretion of the AD. If AD was unsure how to handle a situation, she would ask the Operations Manager (OM) or myself for guidance. -At the April 2016 resident meeting the AD would again discuss a resident could not lose store credit, credit would not be taken away but the resident would not work a day in the future. -There was no coordination with mental health staff and the AWP program. AWP is an activity. -AWP avoided cash. It was prized-based like any other activity, AWP prize was "bigger". Interview on 3/16/16 at 3:45 pm with the Operations Manager revealed:	{D 338}		

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	HAL059021	A. BUILDING: _____ B. WING _____	R-C 03/16/2016

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{D 338}	Continued From page 104 -There is no formal coordination of the AWP program with mental health service providers. -The residents may discuss the AWP with their therapist. -The AOM supervised the AWP and AD. -She did not know the reason for, or when it was determined the credit would be at $1.00 per day. _____ The facility also failed to protect Resident #14 and Resident #2, who each have a known history of substance abuse and both tested positive in January 2016 for methamphetamines, from use of illegal substances while living in the facility. In addition, the facility operated a resident " activity work program " (AWP) that was utilized as a discipline and behavior management tool for its residents, the majority of whom are diagnosed with a serious mental illness or physical or intellectual/developmental disability. The program was managed by the facility activity director with no involvement or oversight from residents ' primary care or mental health providers. Residents were not compensated with a fair and equitable wage for tasks normally performed by paid facility staff. The failure to protect residents and ensure residents were free of exploitation was detrimental to the health, safety and welfare of residents. _____ The facility did not provide an acceptable Plan of Protection to ensure residents were free of neglect and exploitation A Directed Plan of Protection was issued on 3/18/16. THE DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2016.	{D 338}		

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D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to assure the accuracy of 3 of 6 sampled residents' (Residents #4, #6, and #12) electronic Medication Administration Records (eMARs) regarding documenting the administration of Vitamin D2 50,000 units capsules on the residents' MARs. The findings are: A. Review of Resident #6's most recent FL-2 dated 08/04/15 revealed: -Diagnoses of Schizoaffective disorder, and	D 367		

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D 367	Continued From page 106 Vitamin D deficiency. -An order for Vitamin D2 50,000 units once a week. (Vitamin D2 is used to supplement Vitamin D in the body.) Review of Resident #6's record revealed a subsequent physician's order from the resident's primary care Nurse Practitioner dated 12/01/15 ordering Vitamin D2 50,000 units once a month. Review of Resident #6's record revealed the resident's Vitamin D level was documented as 46 on 12/23/15. (Normal range would be 30-100.) Review of Resident #6's January 2016 eMAR revealed: -A preprinted entry for Vitamin D2 50,000 units one capsule once month. -Vitamin D2 50,000 units was scheduled for 8:00 am and documented as administered daily from 01/01/16 to 01/31/16. Review of Resident #6's February 2016 eMAR revealed: -A preprinted entry for Vitamin D2 50,000 units one capsule once month. -Vitamin D2 50,000 units was scheduled for 8:00 am and documented as administered daily from 02/01/16 to 02/2916, except on 02/06/16 and 02/26/16. Review of Resident #6's March 2016 eMAR revealed: -A preprinted entry for Vitamin D2 50,000 units one capsule once month. -Vitamin D2 50,000 units was scheduled for 8:00 am and documented as administered daily on 03/02/16, 03/03/16, 03/04/16, 03/05/16, and 03/06/16.	D 367		

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D 367	Continued From page 107 Interview on 03/07/16 at 8:34 am with a day shift Medication Aide revealed: -She did not routinely administer medications during the day shift but was filling in for Medication Aide staff on vacation. -MAs viewed medications to be administered during a certain time frame by selecting a resident from the group of residents displayed on the computer monitor throughout the day. -Residents' medications appeared on the computer monitor for administration one hour before and up to one after the scheduled time of administration listed on the eMARs. -She routinely administered medications for residents that appeared on the computer screen according to the time of administration. -She did not administer Resident #6's Vitamin D2 50,000 units today because no medication was available to administer: she documented the medication for being ordered. -MAs had an option to select "all" for the medication pass instead of documenting on each medication individually. -If the MA selected the "all" option during documentation, Vitamin D2 50,000 units would be documented as administered since it was scheduled at 8:00 am daily. Interview with a representative at the contract pharmacy on 03/07/16 at 11:50 am revealed: -The pharmacy had a current order for Vitamin D2 50,000 units once monthly dated 12/01/15 that was used to prepare the MARs for January, February, and March 2016. -The representative stated the pharmacy dispensed one Vitamin D2 50,000 units each month if the order was for monthly administration either by cycle fill or per the facility request, depending on how the pharmacy had entered the medication order.	D 367		

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D 367	Continued From page 108 -The pharmacy had dispensed one Vitamin D2 50,000 unit capsule on 12/07/16, 01/10/16 and again on 03/07/16. -The facility would be responsible to notify the pharmacy of a day of the month for administration, otherwise it would appear daily and staff would be responsible to document the day of administration. Interview on 03/10/16 at 1:50 pm with Resident #6 revealed he had not experienced any problems with his medications. Refer to interview on 03/09/16 at 9:20 am with the Operations Manager (OM). Refer to interview on 03/11/16 at 3:30 pm with the Resident Care Coordinator (RCC). B. Review of Resident #12's current FL-2 dated 2/3/16 revealed: -Diagnoses included chronic obstructive lung disease, hypertension, cirrhosis of the liver and a communicable disease. -Medication orders included Vitamin D2 1.25mg (50,000 Units) one tablet every 2 weeks (Vitamin D2 is used to supplement Vitamin D in the body.) Review of the resident's record revealed: -An order dated 10/30/15 for Vitamin D2 1.25mg, one capsule every week. -A subsequent physician's order dated 1/8/16 for Vitamin D2, 1.25mg, one tablet every 14 days. -A laboratory test dated 11/18/15 for Vitamin D level documented as 29.3 (Normal range would be 30-100). Review of a physician's visit note on 9/1/15 revealed: -The resident's Vitamin D level was documented	D 367		

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D 367	Continued From page 109 as 22.8 on 2/4/15 and 46.6 on 8/19/15. (Normal range would be 30-100.) Review of Resident #12's electronic Medication Administration Record (eMAR) for January 2016 revealed: -Vitamin D2 1.25 mg transcription entry for every 2 weeks administration. -Documentation of administration of Vitamin D2 1.25mg every week on 1/6, 1/13, 1/20 and 1/27. -There were no exceptions to the administration. Review of Resident #12's eMAR for February 2016 revealed: -Vitamin D2 1.25 mg transcription entry for every 2 weeks administration. -Documentation of administration of Vitamin D2 1.25mg every week 2/3, 2/10, 2/17, and 2/24. -There were no exceptions to the administration. Review of Resident #12's eMAR for March 2016 revealed: -Vitamin D2 1.25 mg transcription entry for every 2 weeks administration. -Documentation of administration of Vitamin D2 1.25mg every week on 3/2, 3/9 and 3/16. -There were no exceptions to the administration. Interview with the Medication Aide (MA) on 3/16/16 at 10:55 am revealed: -She did document the administration of the Vitamin D today, but did not give it as there was none on the cart available for administration. -She must have selected "all" for the medication pass instead of individually selecting the medication she gave. -She said it was a system error and should have been corrected. -She didn't know why she (the MA) didn't get it (the administration days) "fixed."	D 367		

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D 367	Continued From page 110 Interview with the contract pharmacy on 3/8/16 at 2:50 pm revealed: -The current order for Vitamin D2 1.25mg the pharmacy had on file was dated 9/1/2015 for every two week administration. -The facility would have to request the Vitamin D2 dispensed each month for administration as it would not be on cycle fill. -The pharmacy last dispensed 8 capsules of Vitamin D2 1.25mg for Resident #12 on 9/1/15 to be given twice monthly on Fridays. Interview with Resident #12 on 3/10/16 at 7:00 am revealed -He was not sure if he was receiving Vitamin D2 or not. -He relied on the staff to see that he received his medication his doctor ordered. Refer to interview on 03/09/16 at 9:20 am with the Operations Manager revealed: Refer to Interview on 03/11/16 at 3:30 pm with the Resident Care Coordinator (RCC). C. Review of Resident #4's most recent FL-2 dated 06/02/15 revealed: -Diagnoses of Schizoaffective disorder, Seizure disorder, history head trauma, Hyperlipidemia, COPD, Hypertension, Traumatic Brain Injury and Schizophrenia. -An order for Vitamin D2 50,000 units once a week (Vitamin D2 is used to supplement Vitamin D in the body). Review of Resident #4's record revealed: -A subsequent physician's order from the resident's primary care Nurse Practitioner dated 09/30/15 ordering Vitamin D2 50,000 units twice a	D 367		

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D 367	Continued From page 111 week. -A subsequent physician's order from the resident's primary care Nurse Practitioner dated 02/03/16 ordering Vitamin D2 50,000 units once a month. Review of Resident #4's January 2016 electronic Medication Administration Record (eMAR) revealed: -A preprinted entry for Vitamin D2 1.25mg (50,000 unit) one capsule twice a week. -The Vitamin D2 50,000 units was scheduled for 8:00 am and documented as administered twice a week, on Saturdays and Wednesdays, from 01/01/16 to 01/31/16. Review of Resident #4's February 2016 eMAR revealed: -A preprinted entry for Vitamin D2 1.25mg (50,000 unit) one capsule twice a week, discontinued, with a stop date of 02/03/16. The Vitamin D2 50,000 units was scheduled for 8:00 am and documented as administered on Wednesday, 02/03/16. -A preprinted entry for Vitamin D2 1.25mg (50,000 unit) one capsule once month, start date 02/03/16. -The Vitamin D2 50,000 units was scheduled for 7:00 am and documented as administered daily on 02/04-08/16, 02/12-13/16, 02/19/16, and 02/23-24/16. Review of Resident #4's March 2016 eMAR revealed: -A preprinted entry for Vitamin D2 1.25mg (50,000 unit) one capsule once month. -The Vitamin D2 50,000 units was scheduled for 7:00 am and documented as administered 03/05/16, and 03/06/16.	D 367		

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D 367	Continued From page 112 Interview on 03/11/16 at 12:45 pm with a day shift Medication Aide (MA) revealed: -MA's viewed medications to be administered during a certain time frame by selecting a resident from the group of residents displayed on the computer monitor throughout the day. -Residents' medications appeared on the computer monitor. -She would look at the previous month's eMAR to determine last time the Vitamin D2 was given. -She would expect the pharmacy to correct the eMAR when the order changed. -She did not know reason the medication continued to show-up on a daily basis. -She did not administer Resident #4's Vitamin D2 50,000 units today. -She documented the medication as order completed. Interview on 03/09/16 at 2:35 pm with Resident #4 revealed he was not familiar with his medications. Refer to interview on 03/09/16 at 9:20 am with the Operations Manager (OM). Refer to interview on 03/11/16 at 3:30 pm with the Resident Care Coordinator (RCC). --- Interview on 03/09/16 at 9:20 am with the Operations Manager (OM) revealed: -The contract pharmacy routinely entered the physician's orders on the eMARs. -Physician's orders could be entered by the Resident Care Coordinator (RCC) and Medication Aide staff trained at the facility for order entry. -Orders entered at the facility had to be reviewed, and approved by the RCC or OM before they began to show on the eMAR for administration.	D 367		

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D 367	Continued From page 113 -The facility did not currently have a system in place to routinely review eMARs compared to current orders. -She ran weekly reports for medication administration to review which residents might be refusing medications, and to look at missed medications. -She did not review eMARs for medications scheduled monthly and documented daily administration. -The eMARs accuracy had been discussed with the contract pharmacy representatives and she had corrected some eMARs for administration times and scheduling if staff made her aware of the need. --She was not aware many of the residents with Vitamin D2 50,000 units once monthly were still appearing on the computer monitor each day. Interview on 03/11/16 at 3:30 pm with the Resident Care Coordinator (RCC) revealed: -She was aware the facility had experienced issues with certain medications that were scheduled every 2 weeks or monthly regarding the medications appearing daily and not every other week or monthly. -She had discussed the issue with the pharmacy technician and been told that the pharmacy had to use a day of the month chosen by the facility to enter in the computer in order for the medication to appear only once a month on the computer administration screen. -The RCC stated several medication and treatment orders for residents listed on the eMAR had been corrected for the day of administration by the pharmacy. -She was not aware many of the residents with Vitamin D2 50,000 units once monthly were still appearing on the computer screen each day. -Medication Aide staff had not notified her of the	D 367		

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D 367	Continued From page 114 particular residents with monthly Vitamin D2 50,000 units once a month so she could talk with the pharmacy technician to correct. -She did not have a system in place currently to monitor residents' eMARs compared to the current orders each month. -She did review the eMARs for incomplete documentation (administration holes).	D 367		
{D911}	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: FOLLOW UP TO A TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues TYPE B VIOLATION Based on observations, interviews and record review, the facility failed to treat residents with respect, consideration, dignity, and full recognition of his or her individuality by failing to provide forks and knives as appropriate for meals resulting in residents being unable to cut up their food (including meat), residents having to eat with their hands and residents not having the necessary eating utensils for consumption of some foods such as spaghetti. The findings are: Observations on 03/07/16 of the breakfast meal	{D911}		

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{D911}	Continued From page 115 from 8:00 pm to 9:00 am revealed: -46 residents were present in the dining room. -The meal served consisted of 1 waffle with diet syrup, 2 strips of bacon, and ¾ cups of grits. -All residents were given a spoon with the meal. -Some residents used the side of their spoon to cut the waffles. -Some residents picked up the waffles with their fingers and ate. Confidential interviews with 9 residents revealed: -All residents said they never got knife or fork with meals. -Two resident said spoons were okay they can cut food with side of spoon. -Three residents said it would be nice to have a fork and knife with some meals. -Four residents said staff might cut-up their food, it depends on who staff is and their mood. -One resident said the facility was keeping them safe by not allowing knife and forks with meals. -One resident said he was really tired of having no fork or knife stating how do you eat spaghetti with a spoon, how do you eat a rock hard pork chop with a spoon?The resident bought his own butter knife to cut up his food and facility staff took it away. The resident does not have many teeth and needs to prep his food so he can eat it. If he asked for a knife, he would not get it. He keeps plastic knives and forks in his room and brings with him to the dining room. Interview on 03/07/16 at 8:50 am with the cook revealed: -The facility did not have knives and forks. -She had worked at the facility for several months and had never seen knives and forks. Observation on 03/07/16 at 10:15 am of the Operations Manager's office revealed there was 1	{D911}		

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{D911}	Continued From page 116 box each of 72 forks and 72 spoons. The utensils were in covered in the unopened boxes. Interview on 03/07/16 at 10:16 am with the Assistant Operations Manager revealed: -He had not put the knives and forks in the kitchen. -He had been directed by the owner not to put the knives and forks in the kitchen because "he was fighting that." Observation on 03/08/16 of the lunch meal from 12:30 pm to 1:00 pm revealed: -The meal consisted of country fried steak, mashed potatoes, spinach, and slice of bread. -All 49 residents present for the meal were not provided a complete set of flatware; residents were given a spoon only. -Residents used the spoon to cut the country fried steak. Confidential interviews with 4 residents revealed: -Four residents said a spoon was the only tableware received with meals. -They would like to receive a knife and fork. -Two residents said they were told knife and fork was dangerous because if someone gets mad they can hurt others with the fork or knife (they were unable to recall who told them knife and fork was dangerous). -One resident worked outside the facility, and took a plastic knife from that agency, and he brought it back to the facility. He stated when staff saw the plastic knife they took it away from him. -Two residents said even if the facility did not want to give a knife, they would prefer to at least have a fork. Interview on 03/16/16 at 4:28 pm with the second shift Medication Aide revealed:	{D911}		

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	HAL059021	A. BUILDING: _____ B. WING _____	R-C 03/16/2016

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{D911}	Continued From page 117 -Residents reported their discontent with using spoons, especially when eating spaghetti. -The residents stated it was very difficult to eat spaghetti with a spoon. Interview on 03/16/16 at 2:30 pm with the Operations Manager revealed: -Each resident still had current orders for no fork or knife in their record. -She ran it past the medical practitioner and he was not "keen" on the idea and did not feel comfortable giving the residents a knife and fork. -The Resident Care Coordinator (RCC) talked with another medical nurse practitioner, and a plan could be worked out with that primary care provider. -She will talk with the primary care provider tomorrow to see if the issue is more mental health. The facility's failure to provide forks and knives when needed for meals resulted in residents having to use spoons to cut up foods, such as meats, use spoons to eat foods such as spaghetti and having to use their hands to eat foods. The facility contends that if residents were provided a knife or fork the utensils would be used as weapons by residents, however, there is no documented evidence or individualized assessments to indicate that residents would not be able to utilize eating utensils in a safe manner. The facility's failure to treat residents with respect, consideration, dignity, and full recognition of his or her individuality by failing to provide residents with forks and knives for meals and for food to be cut up or consumed appropriately which is detrimental to the safety and welfare of residents. _____ The facility did not provide an acceptable Plan of	{D911}		

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{D911}	Continued From page 118 Protection to ensure respect and dignity of the residents. A Directed Plan of Protection was issued on 3/18/16. THE DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2016.	{D911}		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure all residents receive care and services which are adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to health care referral. The findings are: Based on interviews and record reviews, the facility failed to ensure contact with Medical Nurse Practitioners or Mental Health Nurse Practitioners for 3 of 9 sampled residents (Residents #2, #3, and #19) regarding aggressive behaviors and current alcohol and drug use (#3); reporting sexual behaviors without precautions of spreading a communicable disease (#19); and testing of illegal drug use when suspected (#2). [Refer to Tag 273 10 NCAC 13F.0902(b) Health	D912		

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D912	Continued From page 119 Care (Unabated Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect and exploitation as evidenced by not providing supervision needed to monitor inappropriate sexual behaviors, elopements or walk offs from the facility and behaviors of deliberate self harm; resident's use of illegal drugs; and the utilization of a resident "activity work program"; and failure by the administrator to ensure compliance and implementation of rules and resident rights. The findings are: A. Based on interviews, record reviews, and observations, the facility failed to assure staff provided supervision in accordance with 3 of 9 residents' (Resident #2, #22 and #9) assessed needs and current symptoms resulting in Resident #2 leaving the facility property multiple times unsupervised looking for drugs, attempted self-harm multiple times, and walking into traffic; Resident #22 leaving the facility property unsupervised and found by a sheriff deputy on the interstate approximately 4-6 miles from the facility; and Resident #9 performing sexual favors for $2.00 and soda. [Refer to Tag 270 10 NCAC 13F.0901(b) (Unabated Type A1 Violation).]	D914		

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D914	Continued From page 120 B. Based on observations, interviews, and record reviews, the facility failed to protect residents from neglect and exploitation by failing to protect residents (#2 and #14) from illegal drug use in the facility and by implementing a resident "activity work program" that was used as a tool for discipline and behavior management which residents were not given fair or equitable compensation for work completed that benefited the facility. [Refer to Tag 338 10 NCAC 13F .0909 Resident Rights (Type B Violation).] C. The administrator failed to identify issues and implement corrective actions to ensure implementation of residents ' rights, including the following: to provide the necessary supervision of residents ' sexual behaviors, aggressive behaviors, and behaviors of deliberate self-harm; to protect residents from use of illegal drugs; to ensure residents are free from exploitation related to the operation of resident " activity work program " that is used as a behavior management and disciplinary tool and for which residents are not compensated with a fair and equitable wage for work that would normally be performed by paid facility staff; to ensure respect, dignity, and full recognition of the residents ' individuality related to the failure to provide knives and forks to residents as necessary for residents to eat their meals; and to ensure notifications of medical providers regarding aggressive behaviors, use of alcohol and illegal drugs and testing of illegal drugs when suspected. The failure to ensure implementation of residents ' rights resulted in serious neglect and exploitation of residents. [Refer to Tag 980 G.S. 131D-25 Implementation]	D914		

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{D980}	Continued From page 121	{D980}		
{D980}	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on observations, interviews and record reviews, the administrator failed to ensure that the management, operations, and policies of the facility ensured implementation of resident rights by the failure to treat residents with respect, consideration, dignity; the failure to provide appropriate care and services; and the failure to provide the services necessary to maintain the residents' physical and mental health as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes, which is the responsibility of the administrator. The findings are: 1. Based on observations, interviews and record review, the facility failed to treat residents with respect, consideration, dignity, and full recognition of his or her individuality by failing to provide forks and knives as appropriate for meals resulting in residents being unable to cut up their food (including meat), residents having to eat with	{D980}		

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{D980}	Continued From page 122 their hands and residents not having the necessary eating utensils for consumption of some foods such as spaghetti. [Refer to Tag D911, G.S. 131D-21(1) Declaration of Residents' Rights]. 2. Based on observation, interview and record review, the facility failed to assure all residents receive care and services which are adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to health care referral. [Refer to Tag D912, G.S. 131D-21(2) Declaration of Residents' Rights]. 3. Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect and exploitation as evidenced by not providing supervision needed to monitor inappropriate sexual behaviors, elopements or walk offs from the facility and behaviors of deliberate self harm; residents' use of illegal drugs; and the utilization of a resident "activity work program". [Refer to Tag D914, G.S. 131D-21(4) Declaration of Residents' Rights]. _____ The administrator failed to identify issues and implement corrective actions to ensure implementation of residents ' rights, including the following: to provide the necessary supervision of residents ' sexual behaviors, aggressive behaviors, and behaviors of deliberate self-harm; to protect residents from use of illegal drugs; to ensure residents are free from exploitation related to the operation of resident " activity work program " that is used as a behavior management and disciplinary tool and for which residents are not compensated with a fair and equitable wage for work that would normally be	{D980}		

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{D980}	Continued From page 123 performed by paid facility staff; to ensure respect, dignity, and full recognition of the residents ' individuality related to the failure to provide knives and forks to residents as necessary for residents to eat their meals; and to ensure notifications of medical providers regarding aggressive behaviors, use of alcohol and illegal drugs and testing of illegal drugs when suspected. The failure to ensure implementation of residents ' rights resulted in serious neglect and exploitation of residents. The Facility did not provide a date of expected compliance nor an acceptable Plan of Protections. A Directed Plan of Protection was issued to the Facility on 3/18/16. THE DATE OF CORRECTION FOR THIS UNABATED A1 VIOLATION SHALL NOT EXCEED April 18, 2016.	{D980}		